

Summary Plan Description



for Arkansas Public School Employees



Managed Benefits:

Health Maintenance Organization (HMO)
Point of Service (POS)
Pharmacy
Behavioral Health
Basic Life Insurance

Claims Administrators:

Health Advantage
NovaSys Health
NMHCRx
CorpHealth
USABLE Life

Plan Administrator:

Employee Benefits Division (EBD)
P.O. Box 15610
Little Rock, AR 72231
Public Site: www.arkansas.gov/dfa/ebd
Member Site: www.arbenefits.org
Email: askebd@dfa.state.ar.us



Employee Benefits Division

ARKANSAS PUBLIC SCHOOL EMPLOYEES' BENEFIT PLAN
SUMMARY PLAN DESCRIPTION
TABLE OF CONTENTS

NOTICE OF PRIVACY PRACTICES	i
NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS	iii
DIFFERENCES IN HMO AND POS PLANS	vi
SUMMARY OF BENEFITS HMO & POS	vii
1.0 PLAN ADMINISTRATION	Page 1
2.0 ELIGIBILITY FOR COVERAGE	Page 2
3.0 EFFECTIVE DATE OF COVERAGE	Page 5
4.0 TERMINATION OF COVERAGE	Page 7
5.0 MEMBER CONTINUATION PRIVILEGES	Page 9
6.0 OUT OF AREA SERVICES	Page 10
7.0 OTHER HEALTH PLANS AND BENEFIT PROGRAMS	Page 13
8.0 MEMBER RIGHTS AND RESPONSIBILITIES	Page 17
9.0 NOTICE OF PHYSICIAN INCENTIVES	Page 19
10.0 GENERAL PROVISIONS	Page 20
11.0 GLOSSARY OF TERMS	Page 22
ATTACHMENT A, MEMBER COMPLAINT AND APPEAL PROCESS	Page A1
ATTACHMENT B, SCHEDULE OF BENEFITS	Page B1
ATTACHMENT C, PRESCRIPTION DRUG COVERAGE	Page C1
ATTACHMENT D, MENTAL HEALTH AND SUBSTANCE ABUSE	Page D1
ATTACHMENT E, USABLE	Page E1
ATTACHMENT F, CONTACT INFORMATION	Page F1
COMMUNITY RESOURCES	BACKPIECE

**Notice of Privacy Practices
From the State of Arkansas
Department of Finance & Administration
Employee Benefit Division**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Introduction

Employee Benefits Division (EBD) is responsible for managing health benefits for the State of Arkansas and the Public School Employees. As a group health plan, EBD is required to secure the privacy of protected health information. The Notice of Privacy Practices describes the types of information, its uses and disclosures and your rights regarding that information.

“Protected health information,” (PHI) means information that is individually identifiable and is protected by privacy regulations. For example, information regarding the health care treatment, payment or operations that can identify you or your dependents. This information is obtained from enrollment forms for health care coverage, surveys, healthcare claims, specialist referrals, your medical records and other sources. You might provide protected health information by telephone, fax, letter or e-mail. Other sources of protected health information include but are not limited to, healthcare providers, such as insurance administrators, network providers, claims processors (hereafter referred to as business partners or affiliates). When used with health related information, any of the following would be considered protected health information:

- Marital status
- Name, address, and date of birth
- Information regarding dependents
- Other similar information that relates to past, present or future medical care
- Sex
- Social Security Number

Disclosures of protected health information not requiring authorization

The law allows the use and disclosure of protected health information without the authorization of the individual for the purpose of treatment, payment, and/or health care operations, which includes, but is not limited to:

- Treatment of a health condition
- Business planning and development
- Coordination of benefits
- Enrollment into the group health plan
- Eligibility for coverage issues
- Complaint review
- Regulatory review and legal compliance
- Payment for treatment
- Claims administration
- Insurance underwriting
- Premium billing
- Payment of claims
- Appeals review

Uses and disclosures for treatment: Your protected health information will be obtained from or disclosed to health care providers involved in your, or your dependents treatment.

Uses and disclosures for payment: Your protected health information will be obtained from and disclosed to individuals involved in your treatment for purposes of payment. Your protected health information may be shared with persons involved in utilization review, or other claims processing.

Uses and disclosures for health care operations: Your protected health information will be used and disclosed for plan operations including but not limited to underwriting, premium rating, auditing, and business planning. In order to ensure the privacy of your protected health information, EBD has developed privacy policies and procedures. During the normal course of business, EBD may share this information with its business partners or affiliates that have signed a contract specifying their compliance with EBD’s privacy policies.

NOTE: Only the minimum necessary amount of information to complete the tasks listed below will be disclosed. Disclosures of personal health information requiring authorization In all situations, other than outlined above, EBD will ask for your authorization to use or disclose your protected health information. EBD will use or disclose information in these circumstances pursuant to the specific purpose contained in your authorization.

- Usually, only the person to whom the protected health information pertains may make authorization.
- In some circumstances, authorization may be obtained from a person representing your interests (such as in the case where you may be incapacitated and unable to make an informed authorization) or in emergency situations where authorization would be impractical to obtain.
- Any 3rd party acting as your advocate (for example, a family member, your employer or your elected official) would require an authorization

Forms

Forms may be obtained from EBD, Forms are:

- Authorization for Release of Protected Health Information
- Revoking Authorization for Release of Protected Health Information

Your Rights

- You have the right to review and copy your protected health information maintained by EBD. If you require a copy of PHI the first request will be provided to you at no cost. A reasonable fee will be charged for shipping additional or subsequent copies.
- You can request a copy of the Notice of Privacy Practices from EBD.
- You have the right to request an accounting, or list, of non-routine disclosures of your protected health information by EBD as of the compliance date. This request must be made in writing.
- You have the right to request a restriction on the protected health information that may be used and/or disclosed. You have the right to request that communications regarding your protected health information from EBD be made at a certain time or location. This request must be in writing and EBD reserves the right to refuse the restriction.
- You have the right to receive confidential communication of PHI at alternate locations and by alternate means.

If you believe your privacy rights have been violated, you have the right to register a complaint with EBD's Privacy Officer:

EBD Privacy Officer
P.O. Box 15610
Little Rock, AR 72231
(501) 682-9656

Or you can send your complaint to the Secretary of Health and Human Services:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

To e-mail the HHS Secretary or other Department officials, send your message to: HHS.Mail@hhs.gov.

Under the HIPAA regulations and guidelines, there can be no retaliation for filing a complaint.

Changes to Privacy Practices

If EBD changes its privacy policies and procedures, an updated Notice of Privacy Practices will be provided to you. Additional information, additional examples and up-to-date privacy notices are maintained on the EBD website at <http://www.accessarkansas.org/dfa/ebd>. This notice became effective on April 14, 2003.

NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this notice because you are or have recently become covered under Arkansas State and Public School Employee Life and Health Insurance Benefits Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description.

The Plan Administrator is: Employee Benefits Division, 1515 West Seventh Street, Suite 300, P. O. Box 15610, Little Rock, Arkansas 72231-5610, (501) 682-9656, Toll-Free (877) 815-1017. Employee Benefits Division is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced, or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child is no longer eligible for coverage under the Plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Employee Benefits Division has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify Employee Benefits Division of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify your employer and/or the Employee Benefits Division. The Plan requires you to make notification within 60 days after the qualifying event occurs. You must send this notice to: Employee Benefits Division, 1515 West Seventh Street, Suite 300, P. O. Box 15610, Little Rock, Arkansas 72231-5610.

Once Employee Benefits Division receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date the Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, or if you are disabled at the time you elect COBRA, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must notify the Employee Benefits Division of the Social Security Administration's determination within 60 days of the date of the determination. If documentation is not provided within the first 60 (sixty) days of coverage, the disability

extension will be denied. This notice should be sent to: Employee Benefits Division, 1515 West Seventh Street, Suite 300, P. O. Box 15610, Little Rock, Arkansas 72231-5610. A copy of the Determination letter must accompany the notification.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that Employee Benefits Division is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Employee Benefits Division, 1515 West Seventh Street, Suite 300, P. O. Box 15610, Little Rock, Arkansas 72231-5610. Documentation of the qualifying event must accompany the notification.

Declining Coverage

A qualified beneficiary must elect coverage within the first 60 (sixty) days after the qualifying event (QE) or date on the election form, whichever is later. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage within the sixty (60) day period.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact The Employee Benefits Division, or you may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep Employee Benefits Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to Employee Benefits Division.

Differences in Point of Service (POS) and Health Maintenance Organization (HMO)

Know your plan selection!

It is very important that you know the type of plan you have selected for coverage. Your plan selection will determine your out of pocket expense as well as the type of benefits available to you.

A Health Maintenance Organization (HMO) requires a member to select a Primary Care Physician (PCP) and obtain a referral for specialty care. Only services which are preformed, prescribed, directed or authorized in advance by the PCP and the Claims Administrators are covered benefits under this Plan except for Emergency or urgent care. The selection of a PCP is not optional under an HMO plan. **No benefits are available under an HMO without the formal selection of a PCP.**

A Point Of Service ("POS") Plan provides a Member the option of receiving Covered Services, in addition to Emergency and Urgent Care services, without first receiving an authorization from the Member's PCP or Claims Administrator. However, the Claims Administrator does not cover such "Out-of-Network" services to the same degree as services authorized or provided by the Member's PCP. In a POS, a Primary Care Physician must authorize and direct your care to optimize your benefits. See definition for Point of Service or POS option.

The Plan does not cover Out-of-Network services until the Member has satisfied an annual Deductible. Once the Deductible is satisfied, the Member pays the Out-of-Network Coinsurance. It is important to note that Out-of-Network services, provided through the POS feature are not applied to In-Network Annual Coinsurance Maximum. For certain services no coverage is provided Out-of-Network, i.e. transplants.

Failure to obtain a Referral for In-Network services that require a PCP Referral will result in payment at the Out-of-Network rate. The Out-of-Network reimbursement rate is 70% of the maximum allowable cost. The following page shows an example of the possible difference between billed charges and the maximum allowable.

Arkansas Public School Employees Benefit Summary Health Advantage, NovaSys Health and QualChoice		HMO
This Benefit Summary is part of the Summary Plan Description, and is subject to all benefit terms, exclusions, and limitations contained therein.		
Deductible	None	None
Lifetime Maximum	None	None
<u>COVERED BENEFITS AND SERVICES</u>	<u>COPAYMENT</u>	<u>COINSURANCE</u>
Annual Coinsurance Limit - Individual	Unlimited	\$1500
Annual Coinsurance Limit - Family - Two family members have met the individual out-of pocket expenses	Unlimited	\$3000
Professional Services		
Primary Care Physician Visits	\$25	0%
Specialist Visits/Specialty Care Services (including Specialty Services provided by the PCP)	\$35	0%
Preventive Care Services - dental and vision screenings not covered		
<i>See Preventative Care chart in this publication for additional coverage detail</i>	\$0	0%
Hospital Services (Including Physician Services)		
Inpatient Services (Semi-private room) Copayment charged per admission except in case of direct transfer to another facility. Maximum of 3 Copayments per Member per Contract Year) Requires pre-authorization by QualChoice	\$500 per admission	20%
Outpatient Hospital Services except for outpatient surgery	\$0	20%
Outpatient Services (Including Physician Services)		
Diagnostic Services - Lab and X-ray (Services and procedures performed outside the PCP office)	\$0	20%
Outpatient Surgical Services (Facility Copayment applies)	\$0	20%
Allergy Services		
Injection with no office visit	\$0	20%
Services by Specialty Providers (office visit and testing) - PCP \$25	\$35	20%
Maternity and Family Planning Services		
Prenatal and Postnatal outpatient care (Copayment first visit only)	\$25	20%
Inpatient Maternity Services (Copayment per admission)	\$500	20%
Infertility Counseling (treatment for infertility is not a covered benefit under this plan. Infertility is covered up to diagnosis.)	\$25 PCP \$35 Specialist	0%
Infertility Testing (outpatient surgery Copayment may apply)	\$100	20%
Ambulance Services (limited to \$1000 per Member per Contract Year Does not include charges for emergency medications during transport)	\$0	20%
Emergency Care Services		
Emergency Room Visit *	\$100	20%
Urgent Care Center	\$100	20%
Observation Services	\$100	20%
<i>*Emergency Care Copayment waived if Member is admitted directly to the Hospital or transferred directly to another facility from that emergency admission.</i>		

COVERED BENEFITS AND SERVICES (CONT)	COPAYMENT	COINSURANCE
Rehabilitation Services		
Inpatient Rehabilitation Services (Limited to 60 days per Member per Contract Year)	\$500 per admission	20%
Outpatient Rehabilitation Services: Physical, Occupational, and Speech Therapy; Chiropractic Services and Cardiac Rehabilitation (Limited to 60 aggregate visits per Member per Contract Year)	\$0	20%

See Behavioral Health Section Of This SPD	Not Covered by	Not Covered by
Durable Medical Equipment (DME) and Medical Supplies	0%	20%
Prosthetic and Orthotic Devices (Limited to \$15,000 per Member per Contract Year)		
Diabetes Management Services (Not subject to DME/Medical Supplies annual maximum)	0%	20%
Insulin Pump and Insulin Pump Supplies	20%	0%
Diabetic Supplies and Equipment (except for insulin pump and Supplies)	Prescription Card	Prescription Card
Diabetic Self Management Training	\$25 per program	0%
Ostomy Supplies	0%	10%
Home Health Services (Nursing Visits are limited to 120 visits per Member per Contract Year) Requires Pre-authorization by QualChoice	\$0	20%
Home IV Drugs and Solutions Requires Pre-authorization by QualChoice		20%
Skilled Nursing Facility (Limited to 60 Days Per Member Per Contract Year)	\$500	20%
Hospice Care (Must be pre-approved by Claims Administrator)	\$0	0%
Dental Care Services Damage to non-diseased teeth due to accident/injury	\$25	20%
Reconstructive Surgery		
Correct defects due to Accident or Surgery. Children 12 years and under for specific conditions.	Applicable Copayment	20%
Injectable Medications Medications when covered by Claims Administrator (Subject to exclusions and limitations)	Office Copayment may apply	20%
TMJ - Covered when diagnosed as medical condition. (Limited to \$500 Lifetime Maximum per Member)	\$25	Applicable co-insured will apply if a procedure is performed
Organ Transplant Services - must be pre-authorized by Claims Administrators (Two transplants per Member per Lifetime) (Up to \$10,000.00 lifetime for travel and lodging when in conjunction with transplant services)	\$500 per admission	20%

Under an HMO, a PCP must be chosen and PCP referrals are required for specialty care. Health Advantage requires a PCP be chosen in their POS option. QualChoice will pay claims at the out-of-network benefit level in their POS option if a PCP is not selected.

Arkansas Public School Employee Benefit Summary Health Advantage, NovaSys Health and QualChoice		POS	
This Benefit Summary is part of the Summary Plan Description, and is subject to all benefit terms, exclusions, and limitations contained therein.			
	In-Network		Out-of-Network
Deductible - Individual	None	None	\$500
Deductible - Family	None	None	\$1000
Lifetime Maximum	None	None	\$1,000,000
COVERED BENEFITS AND SERVICES	COPAYMENT	COINSURANCE	COINSURANCE
Annual Coinsurance Limit - Individual	Unlimited	\$1500	\$5000
Annual Coinsurance Limit - Family	Unlimited	\$3000	\$10000
Professional Services			
Primary Care Physician Visits	\$25	0%	40% after ded
Specialist Visits/Specialty Care Services (including Specialty Services provided by the PCP)	\$35	0%	40% after ded
Preventive Care Services			
See Preventative Care chart in this publication for additional coverage detail	\$0	0%	Not Covered
Hospital Services (Including Physician Services)			
Inpatient Services (Semi-private room) Copayment charged per admission except in case of direct transfer to another facility. Maximum of 3 Copayments per Member per Contract Year) Requires pre-authorization by QualChoice	\$500 per admission	20%	40% after ded
Outpatient Hospital Services except for outpatient surgery	\$0	20%	40% after ded
Outpatient Services (Including Physician Services)			
Diagnostic Services - Lab and X-ray. (Services and procedures performed outside the PCP office)	\$0	20%	40% after ded
Outpatient Surgical Services (Facility Copayment applies)	\$100	0%	40% after ded
Allergy Services			
Injection with no office visit	\$0	0%	40% after ded
Services by Specialty Providers (office visit and testing)	\$35	0%	40% after ded
Maternity and Family Planning Services			
Prenatal and Postnatal outpatient care (Copayment first visit only)	\$25	20%	40% after ded
Inpatient Maternity Services (Hospital Copayment)	\$500	20%	40% after ded
Infertility Counseling (treatment for infertility is not a covered benefit under this plan. Infertility is covered up to diagnosis.)	\$35	0%	40% after ded
Infertility Testing (outpatient surgery Copayment may apply)	\$0	0%	40% after ded
Ambulance Services (Limited to \$1000 per Member per Contract Year. Does not include charges for emergency medications during transport)	\$0	20%	40% after ded
Emergency Care Services			
Emergency Room Visit *	\$100 Copayment and 20% Coinsurance		
Urgent Care Center	\$100 Copayment and 20% Coinsurance		

*Emergency Care Copayment waived if Member is admitted directly to the Hospital or transferred directly to another facility from that emergency admission. (Coverage is the same for In-Network and Out-of-Network Services)			
COVERED BENEFITS AND SERVICES (CONT)	COPAYMENT	COINSURANCE	COINSURANCE
Rehabilitation Services			
Inpatient Rehabilitation Services (Limited to 60 days per Member per Contract Year)	\$500 per admission	20%	40% after ded
Outpatient Rehabilitation Services: Physical, Occupational, Speech Therapy, Chiropractic Services, and Cardiac Rehabilitation. (Limited to 60 aggregate visits per Member per Contract Year)	\$0	20%	40% after ded
Behavioral Health and Substance Abuse Services Are Not Covered By Your HMO or POS Plan but by Corphealth- see Behavioral Health section of this SPD	See Behavioral Health Attachment	See Behavioral Health Attachment	See Behavioral Health Attachment
Copayment and Coinsurance amounts for Behavioral Health/ Substance Abuse do not apply to the Physical Health Annual Coinsurance Limit and visa versa.			
Durable Medical Equipment (DME) and Medical Supplies, and	0%	20%	40% after ded
Prosthetic and Orthotic Devices (Limited to \$10,000 per Member per Contract Year)	0%	20%	40% after ded
Diabetes Management Services (Not subject to DME/Medical Supplies annual maximum)		20%	40% after ded
Insulin Pump and Insulin Pump Supplies	20%	0%	40% after ded
Diabetic Supplies and Equipment (except insulin pump and insulin pump supplies)	Prescription Drug Card Only	Prescription Drug Card Only	Prescription Drug Card Only
Diabetic Self Management Training	\$25 per program	0%	40% after ded
Ostomy Supplies		10%	40%
Home Health Services (Nursing Visits are limited to 120 visits per Member per Contract Year) Required Pre-authorization by QualChoice	\$0	20%	40% after ded
Home IV Drugs and Solutions Requires Pre-authorization by QualChoice		20%	40% after ded
Skilled Nursing Facility (Limited to 60 Days Per Member Per Contract Year)	\$250	20%	40% after ded
Hospice Care (Must be approved by Claims Administrator)	\$0	0%	40% after ded
Dental Care Services Damage to non-diseased teeth due to accident/injury See Attachment B: Schedule of Benefits	\$25	20%	40% after ded
Reconstructive Surgery			
Correct defects due to Accident or Surgery. Children 12 years and under for specific conditions.	Applicable Copayment	20%	40% after ded
Injectable Medications Medications when covered by Claims Administrator (Subject to exclusions and limitations)	Office Copayment may apply	0%	40% after ded
TMJ - Covered when diagnosed as medical condition. (Limited to \$500 Lifetime Maximum per Member)	\$20 PCP \$25 Spec	0%	40% after ded
Organ Transplant Services - must be approved by Claims Administrators (2 transplants per Member per Lifetime) (Up to \$10,000 lifetime towards transportation and lodging in conjunction with transplant services)	\$250 per admission	20%	Not Covered

Under an HMO, a PCP must be chosen and PCP referrals are required for specialty care. Health Advantage requires a PCP be chosen in their POS option. QualChoice does not require a PCP be selected in their POS option but benefits will be paid at the out-of-network benefit level if no PCP chosen. For In-Network benefits, services must be performed, arranged, or authorized by the Primary Care Physician, except for Emergency Care. The Member is responsible for difference between billed charges and Allowable Charges for services covered at the Out-of-Network benefit level.

Coverage for all services is subject to Claims Administrator's Allowable Charges.

ENHANCED WELLNESS BENEFIT

Preventative (wellness) services are covered at 100% according to the schedule below under both the State and Public School HMO and POS plans. Services are covered at in-network physicians only. Services may be obtained from more than one physician. Services that are not for screening or preventative in nature, but rather due to illness or specific condition, are subject to the standard schedule of benefits and will be subject to co-payments, co-insurance and deductible, if applicable. Contact carrier for more details.

Preventive Care Services	Co-Pay	Co-Insurance
Immunizations	\$0	0%
Well Baby Care (under 2 years of age)	\$0	0%
Well Child Care (over 2 years of age)	\$0	0%
Physical Exams - Adults (limit 1 per year at no cost)	\$0	0%
Routine Mammogram (limit 1 per year at no cost)	\$0	0%
Annual Routine Gynecological visit (limit 1 per year at no cost)	\$0	0%
New Baby Well Baby Visits		
Under 1 year		Initial comprehensive preventative medicine evaluation and management of an individual. Including an age and gender appropriate history, examination, counseling or anticipatory guidance/ risk factor reduction interventions, and ordering of appropriate immunizations laboratory/diagnostic, new patient; infant (age under 1 year)
Under 1 year		Periodic comprehensive preventative medicine reevaluation and management of an individual. Including an age and gender appropriate history, examination, counseling or anticipatory guidance/ risk factor reduction interventions, and the ordering of appropriate immunizations, laboratory/ diagnostic, established patient; infant (age under 1 year)
Newborn Care		Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference with parents.
Preventive Care Services - Adults (age 18 and over)		
Annual Physical Office Visit	\$0	0%
Screening Mammogram (including Breast Exam) age 40 and over	\$0	0%
Pap Smear	\$0	0%
Prostate Specific Antigen (PSA) age 40 and over	\$0	0%
Colorectal Cancer Screening (Choice of the following beginning at 50)	\$0	0%
Fecal occult blood test annually and one of the following:	\$0	0%
Flexible sigmoidoscopy every 5 years	\$0	0%
Colonoscopy once every 10 years	\$0	0%
Double contrast barium enema once every 5 years	\$0	0%
Cholesterol and HDL - Once every 5 years for males age 35 and older and once every 5 years for females 45 and over	\$0	0%
Immunizations - Adults (members age 18 and over)	\$0	0%
Diphtheria, every 10 years	\$0	0%
Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years	\$0	0%
Hepatitis B (Hep B) - once per lifetime	\$0	0%
Influenza, annually	\$0	0%
Pneumococcal Conjugate, adult over 55	\$0	0%

Preventive Care Services - Child (under age 18)	Cost	
Six Visits	\$0	Birth to age 1
Three Visits	\$0	Age 1 to 2
Annual Visits	\$0	Age 3 to 4
Annual Visits	\$0	Age 5 to 11
Annual Visits	\$0	Age 12 to age 17
Lead level	\$0	9 months to 24 months
Vision Screening	\$0	3-6, 8, 10, 12 and 15 months
Hearing Screening	\$0	4-6, 8, 10, 12 and 15 months
Immunizations - Children	\$0	
Hepatitis B (Hep B)	\$0	
Hemophilus influenza b (hib)	\$0	
Hepatitis B (Hep B) and Hemophilus influenza b (hib) combo	\$0	
Diphtheria	\$0	
Diphtheria and Tetanus toxiod for ages over seven (Td)	\$0	
Diphtheria and Tetanus toxiod and acellular pertussis (DtaP)	\$0	
Diphtheria and Tetanus toxiod and whole cell pertussis (DTP)	\$0	
Diphtheria and Tetanus toxiod and whole cell pertussis and Hemophilus influenza b (DTP-Hib)	\$0	
Diphtheria and Tetanus toxiod and whole cell pertussis, Hemophilus influenza b , and inactivated poliovirus (DTaP-Hib-IPV)	\$0	
Influenza ages 6-35 months	\$0	
Tetanus	\$0	
Polio, live, oral use (OPV)	\$0	
Polio, inactivated, subq use (IPV)	\$0	
Measles, live for subq use	\$0	
Rubella	\$0	
Mumps	\$0	
Varicella	\$0	
Measles, Rubella	\$0	
Measles, Mumps, Rubella (MMR)	\$0	
Measles, Mumps, Rubella and Varicella (MMRV)	\$0	
Pneumococcal Conjugate, for children under 5	\$0	
Pneumococcal Conjugate, adult or immunosuppressed, children age 2 or older	\$0	

ARKANSAS PUBLIC SCHOOL EMPLOYEES

HMO and POS SUMMARY PLAN DESCRIPTION

1.0 PLAN ADMINISTRATION

- 1.1 This document is a summary description of Arkansas Public School Employees' Insurance program.

Plan Administrator: The Employee Benefit Division for the State of Arkansas Department of Finance and Administration ("EBD") has established and maintains the Arkansas Public School Employees' Insurance Plan (the "Plan ") for active and retired Arkansas Public School employees and their eligible dependents. EBD serves as the Plan Administrator and administers the Plan in accordance with applicable law and actively promotes the Plan to Arkansas State and Public School Employees.

- 1.2 Claims Administrator: Health Advantage, NovaSys Health and QualChoice serve as the Claims Administrators for the Plan. As the Claims Administrators, Health Advantage, NovaSys Health and QualChoice have authority and full discretion to determine all questions arising in connection with coverage under the Plan, including interpretation of Plan language, and findings of fact with regard to any such questions. The actions, determinations and interpretations of Health Advantage, NovaSys Health and QualChoice acting on behalf of the Plan within the scope of this authority shall be conclusive and binding on the Plan and the Member, subject to the Complaint and Appeal Process set out in Attachment A.
- 1.3 Assignment of Benefit: No assignment of benefits by a Member shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the provider of service or to a Member.
- 1.4 Relationship to Plan Providers: Health Advantage, NovaSys Health QualChoice and Plan Providers are independent contractors. Health Advantage, NovaSys Health and QualChoice are **not** providers of health care services but instead offer health plan coverage for services provided by treating provider(s). Health Advantage, NovaSys Health and QualChoice do not recommend, direct or control delivery of any health care services. Plan Providers are not agents or employees of Health Advantage, NovaSys Health or QualChoice. Neither Health Advantage, NovaSys Health, or QualChoice nor any employee of said Claims Administrator is an employee or agent of Plan Providers. The Claims Administrators shall not be liable for any claim or demand because of damages incurred by, or in any manner connected with, any injuries suffered by the Member while receiving care from any Plan Provider.
- 1.5 Patient/Provider Relationship: Plan Providers maintain a provider-patient relationship with Members and are solely responsible to the Members for all health care services. A Member should always look to his or her physician(s), not to the Claims Administrator, for any medical advice or treatment.
- 1.6 Refusal to Accept Treatment: Certain Members may, for personal reasons, refuse to accept procedures or treatment by a Plan Physician. Plan Physicians may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. Plan Physicians shall use their best efforts to render all necessary and appropriate Professional Services in a manner compatible with a Member's wishes, insofar as this can be done consistent with the Plan Physician's judgment as to the requirements of proper medical practice. If a Member refuses to follow a recommended treatment or procedure, and the Plan Physician believes that no professionally acceptable alternative exists, such Member shall be so advised. In such case, Health Advantage, NovaSys

Health and QualChoice shall have no further responsibility to provide coverage for care for the condition under treatment.

- 1.7 Identification Card: Cards issued by Health Advantage and QualChoice to Members pursuant to this Summary Plan Description are for identification purposes only. The identification card confers no right to coverage for services or other benefits under this Summary Plan Description. To be entitled to coverage of any services or benefits, the holder of the identification card must, in fact, be a Member on whose behalf all applicable premiums under this Summary Plan Description have actually been paid. Any person receiving services or benefits for which he is not entitled to coverage under the provisions of this Summary Plan Description will be liable for the full cost of such services or benefits, and agrees to cooperate fully with Health Advantage, NovaSys Health and QualChoice in recovering any such payments for services from providers, and, if such amounts are not promptly refunded to the Claims Administrator, agrees to reimburse the Claims Administrator the full amount of any such payments.

2.0 ELIGIBILITY FOR COVERAGE

- 2.1 Subscriber Coverage: To be eligible a Subscriber must:
1. Satisfy the group Waiting Period and work on a full time (900 hours or 720 hours for bus drivers) basis for an Arkansas Public School, Co-ops, or Charter Schools; or
 2. Be an eligible retiree under one of the approved retirement systems
- 2.2 Dependent Coverage: Eligible Dependents are the Subscriber's:
1. Spouse;
 2. Unmarried children, if, but only if, they fall into one or more of the following categories:
 - a. a Child less than age nineteen (19);
 - b. a Child who is enrolled and regularly attending on-campus classes as a full-time student at an accredited college, university or vocational training school, under age twenty-seven (27) and who is financially dependent on the Subscriber;
 - c. a Child of any age who is medically certified as totally disabled due to mental or physical incapacity and chiefly dependent on the Subscriber for financial support, provided the requirements of Section 2.4, below, are met.
- 2.3 Subscriber must be Covered: In order for a Subscriber's Dependent to be eligible for coverage, the Subscriber must be eligible for and have coverage.
- 2.4 Proof of Mental or Physical Incapacity: In order for dependent coverage to be provided due to mental or physical incapacity, proof of the Child's dependency and incapacity must be furnished to the appropriate Claims Administrator prior to the Child's attainment of the applicable limiting age referenced in sections 2.2.2.a and 2.2.2.b, above. Subsequent evaluation for continued incapacity and dependency may be required by the Claims Administrator, but not more frequently than once per year. Newly eligible Subscribers may enroll an incapacitated dependent child provided the disability commenced before the limiting age, and the child has been continuously covered under a health benefit plan as a Dependent of the Subscriber since before attaining the limiting age.
- 2.5 Student Coverage, Conditions and Verification:
1. When a Dependent is eligible for coverage on a student basis as set forth in Section 2.2.2.b, above, coverage is conditioned upon continued student status and documentation of such status as outlined in Section 2.2.2.b.
 2. The Subscriber and Dependent are each responsible to notify EBD of a change in student status of a Child; however, EBD may request verification of student status each academic term.

3. Both the Subscriber and the Dependent are obligated to respond promptly and fully to any EBD student verification request, and Subscriber and Dependent hereby authorize any school office or representative to release to EBD all information concerning the Dependent's enrollment, academic or disciplinary record, attendance record and continued student status.
4. If EBD is unable to verify continued student status as required by Section 2.2.2.b hereof, or if either the Subscriber or Dependent fails to promptly respond to inquiries from EBD, or fails to authorize release of any information to EBD, the Dependent's coverage may be terminated, regardless of the Dependent's actual student status, upon fifteen (15) day's written notice from EBD.
5. If a Dependent covered due to student status ceases to be enrolled or regularly attending on-campus classes, all coverage under this SPD shall terminate on the earliest to occur of (a) the date on which the Dependent formally withdrew from school enrollment; or (b) the date on which the Dependent notified any school office or official that the Dependent intended to withdraw or cease attendance; or (c) the date on which the Dependent or any parent, guardian or representative of the Dependent was notified by the school that enrollment as a student would be terminated, suspended or placed on administrative hold or probation; or (d) the date on which the Dependent leaves or abandons school or fails to meet minimal school attendance standards or testing requirements for continued enrollment as a full-time student; or (e) the date on which the Dependent last attended any classes prior to the occurrence of any of the events described in the preceding four subparagraphs (a), (b), (c) or (d) of this paragraph (5).
6. If a question is raised as to a Dependent's student status, EBD may instruct the Claims Administrator to withhold processing or payment of any claim, pending the outcome of EBD's investigation and verification of student status. Claims for services received after a Dependent ceases to be enrolled or regularly attending on-campus classes under any of the conditions outlined in paragraph (5) above, are not covered and shall be denied by EBD, regardless of when EBD learns of the termination of student status. If the Claims Administrator has processed or paid any claims before learning that student status terminated, Subscriber and Dependent agree to cooperate fully with the EBD and the Claims Administrator in recovering any such payments from providers, and, if such amounts are not promptly refunded to the Claims Administrator, Subscriber and Dependent agree to reimburse the Claims Administrator the full amount of any such payments.

2.6 Change of Residence: A Member who transfers his or her residence and place of employment out of the Service Area may be eligible to continue his or her coverage under this Plan at the sole discretion of the Plan Administrator (EBD). See Section 6, Out of area services.

Health Advantage: In order to be eligible for consideration, members must notify Health Advantage within thirty (30) days of the transfer. Services covered by Health Advantage are only available within the Service Area, except as otherwise provided by the Plan. If a member is covered under the Point of Services (POS) Plan, he or she may access care outside of the network with an increase in his or her financial responsibility.

QualChoice: When a member is traveling out of the QualChoice service area for some purpose other than the receipt of medical care, or a covered dependent student residing out of the Services Area, QualChoice will provide Benefits for illness or injury if the following criteria are met:

- You have selected a Network Primary Care Physician;
- The condition is one of rapid onset, or is the result of an injury;
- Return to our Services Area to receive treatment from your Network Primary Care Physician is not feasible;

- The treatment is determined to be medically necessary;
- QualChoice is notified prior to inpatient admission surgery, consultation or testing after the medical screening is performed at an emergency room, or as soon as you or a person acting on your behalf is physically able to do so; and
- All claims and proof of services are submitted to QualChoice in writing within sixty (60) days after the date on the original bill. These services may be subject to the pre-authorization process.
- If you are covered under the Point of Services (POS) Plan, you may access care outside of the network with an increase in your financial responsibility.

NovaSys Health

NovaSys Health Members that live, work or who are on extended travel outside the Service Area for more than 90 days may be eligible for a temporary Out of Area Classification. If approved by NovaSys Health, the member uses his/her NovaSys Health ID Card to access services covered by NovaSys Health on the Member's Group Health Plan. Services are covered at the In-Network benefit level when provided by a Beech Street Corporation provider listed in the Beech Street Corporation Network when services are delivered outside the NovaSys Health Regional Network. Members must present their ID card at the time of service. Claims are billed with the Member's ID number and routed to NovaSys Health for payment. The Member's out of pocket expenses are limited to the Member's In-Network Deductible, Copayment, and/or Coinsurance.

Members eligible for this benefit are:

- Members or Covered Dependents on Extended Business. Members that travel outside the State of Arkansas for more than ninety (90) days but less than one hundred eighty (180) days are eligible for a temporary Out of Area Classification not to exceed 180 days. Only one renewal per year is allowed.
- Student Covered Dependents Attending School Outside the Service Area. Dependent Students attending school Outside the NovaSys Health Regional Network area for at least ninety (90) consecutive days are eligible for an Out of Area Classification for the school year. Renewal is required at least annually.
- Dependents Residing Outside the Service Area. Dependents (spouse or child) residing Outside the NovaSys Health Regional Network area for at least ninety (90) consecutive days are eligible for an Out of Area Classification. Renewal is required at least annually.

The Member must complete the application requesting a temporary Out of Area Classification for the eligible family member. The completed form must be either faxed to 501-219-4455 or mailed to: NovaSys Health Customer Service, P.O. Box 25310, Little Rock, AR 72221-25310. If approved, the Member will be sent an ID card and benefit materials to use when accessing covered services in the area they are residing. The maximum time for which the Out of Area Classification can be assigned is six months for eligible Subscribers and one year for eligible dependents. A completed application is required for each renewal period.

2.7 Military Duty:

- a. An employee may choose to continue the Public School Employee group health and life insurance coverage during Military Leave. The employee must pay the employee health/life contribution (the amount that is normally deducted from his/her pay) and the school district will continue to contribute a minimum of \$122.00 per active employee. The employee must provide the School Business Official a copy of the military/deployment orders. (Payment for the employee's basic life coverage is limited

to six (6) months.)

- b. If an employee chooses to discontinue the Public School Employee group health and life insurance coverage while on Military leave, he or she is eligible for reinstatement of his or her school health and life insurance coverage (for both insured and family) without health questions and without pre-existing conditions waiting periods upon return to active public school employment. A ninety (90)-day special enrollment period begins on the date of returning to active status and the employee must make application within that ninety (90)-day period. The application should be submitted to the agency insurance representative who will send the application to the Employee Benefits Division for processing. A copy of the forms should be retained for the School Business Official's records. The coverage will be effective the first of the month following the application or the first day of return to work after appropriate premium payment is made to EBD.

3.0 EFFECTIVE DATE OF COVERAGE

- 3.1 Application and Effective Date: In order for a Subscriber's coverage to take effect, the Subscriber must submit a written application for coverage for Subscriber and any Dependents. The Effective Date(s) of coverage shall be the date indicated by the Claims Administrator on the ID card, ID card packet or letter issued to Members by the Claim Administrator.
- 3.2 Employees and Dependents on Contract Effective Date: Coverage under this Plan shall become effective on the Group Contract Effective Date for all Subscribers and Dependents for whom an enrollment application is completed during the Annual Open Enrollment Period prior to the effective date of the Plan.
- 3.3 Initial Enrollment for New Employees: If the School Business Official receives the Subscriber's enrollment application within thirty (30) days of the Subscriber's date of employment, the Subscriber's coverage will become effective on the first day of the month following the expiration of the Waiting Period.
- 3.4 Coverage in the Case of Late Enrollment: If an employee or an employee's dependent who is eligible for coverage does not make application for coverage in the Plan when initially eligible for coverage, the employee or dependent can not subsequently obtain coverage, except during a Special Enrollment Period or Annual Enrollment Period .
- 3.5 Annual Open Enrollment Period: Annually, during the month of August, Arkansas Public School employees who are eligible for coverage may enroll in the Plan. During the Annual Open Enrollment Period, employees covered in the Plan may change their Claims Administrator selection and that of their covered dependents, to any one of the carriers providing claims administration under the Plan. Enrollments and selection changes made during the Annual Open Enrollment Period become effective on the first day of the new plan year (October 1st).
- 3.6 Initial Enrollment Period for Existing Dependents: If the Subscriber has eligible Dependents on the date the Subscriber's coverage begins, the Subscriber's Dependents' coverage will begin on the Subscriber's Effective Date if the Subscriber submits a written application for Dependents' coverage within thirty (30) days of the Subscriber's Effective Date.
- 3.7 Initial Enrollment Period for Newly Acquired Dependents: Documentation appropriate to the situation is required for all newly acquired dependents i.e. marriage license, birth certificate or adoption papers. If the Subscriber acquires new eligible Dependents after the date the Subscriber's

coverage begins, coverage for a new Dependent will become effective in accordance with the following provisions:

1. Spouse: When a Subscriber marries and wishes to have their spouse covered, the Subscriber shall submit an application or change form within thirty (30) days of the date of marriage. The Effective Date will be the first of the month following the date of marriage. If the Subscriber submits the application or change form after the thirty (30) day period, coverage for the Subscriber's spouse will become effective in accordance with the provisions for Late Enrollees. See Section 3.4, above.
2. Newborn Children: Coverage for a Subscriber's newborn Child shall become effective as of the date of birth if the Subscriber gives EBD notice of the Child by submitting an application or change form to EBD for the Child within thirty (30) days of the Child's date of birth, if the Subscriber has coverage for the "Subscriber only" or "Subscriber and Spouse". If the Subscriber has coverage for Subscriber and Children or Subscriber and Family at the time the Child is born, the Subscriber must give EBD notice within ninety (90) days of the Child's birth. If the Subscriber submits the application or change form after the applicable thirty (30)-day or ninety (90)-day time period, coverage for the subscriber's newborn Child will become effective in accordance with the provisions for Late Enrollees. See Section 3.4, above.
3. Court Ordered Coverage for a Child: If a court has ordered the Subscriber or the Subscriber's Spouse to provide coverage for a Child, coverage will be effective on the first day of the month following the date EBD receives written notification and satisfactory proof of the court order. If the Subscriber fails to apply to obtain coverage for a Child, EBD shall enroll the Child on the first day of the month following the Claim Administrator's receipt of a written application from the custodial parent of the Child, a child support agency having a duty to collect or enforce support for the Child, or the Child. In the event a court has ordered an Arkansas Public School Employee who is not covered by the Plan to provide coverage for a child, the employee will be enrolled with the child on the first day of the month following the Claim Administrator's receipt of a written application from the Group, a custodial parent of the Child, a child support agency having a duty to collect or enforce support for the Child, or the Child.
4. Newly Adopted Children: Coverage for a Child placed with a Subscriber for adoption or for whom the Subscriber has filed a petition for adoption, shall begin on the date the Child is placed for adoption or the date of the filing of the petition for adoption, provided an application for the Child's coverage is submitted to EBD within sixty (60) days after the placement or the filing of the petition. The coverage shall begin from the moment of birth if the petition for adoption or placement for adoption occurred and the application for coverage is submitted to EBD within sixty (60) days of the Child's birth. If the Subscriber submits the application or change form after such sixty (60) day period, coverage for the adopted Child will become effective in accordance with the provisions for Late Enrollees. See Section 3.4, above. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.
5. Other Dependents: Written application for enrollment must be received by EBD within thirty (30) days of the date that any other dependent first qualifies as an eligible Dependent. Coverage will become effective on the first day of the month following the date that application for coverage is received by EBD. If the Subscriber submits the application or change form after the thirty (30) day period, coverage for the Dependent will become effective in accordance with the provisions for Late Enrollees. See Section 3.4, above.

- 3.8 Subscriber's Effective Date Controls: In no event will a Dependent's coverage become effective prior to the Dependent's Subscriber's Effective Date.
- 3.9 Relocation into Service Area: An employee or a Subscriber's Dependent who previously resided outside the Service Area and who relocates to the Service Area and who meets the eligibility requirements of Section 2.0, may enroll in the plan if a written application is submitted to the School Business Official. If written application is submitted within thirty (30) days following the relocation, the Effective Date of coverage begins on the first day of the month following the date of the application and the satisfaction of any applicable Waiting Period. If written application is not made within thirty (30) days of the relocation, coverage will become effective in accordance with the provisions for Late Enrollees. See Section 3.4, above.
- 3.10 Special Enrollment Period: The 30 day period during which time an employee or employee's dependent may enroll in the Plan, after his or her initial Eligibility Period or Annual Enrollment Period and not be a Late Enrollee. Special Enrollment Periods occur in two instances:
- 1 After the Termination of Another Health Plan: A Special Enrollment Period occurs (1) after an employee's or dependent's coverage under another health plan terminated as a result of loss of eligibility, or (2) after the employer providing such other health plan terminated its contributions. In order for the Special Enrollment Period to apply, the employee must have stated in writing, at the time coverage under the Plan was first offered, that the employee or dependent(s) were declining coverage because of coverage under such other health plan. The Effective Date of Coverage will be the first day of the month following receipt of the application for coverage.
 2. After the Addition of a Dependent: A Special Enrollment Period occurs for an employee, employee's spouse or employee's new dependent child (1) after the employee marries, (2) after an employee's child is born, or (3) after an employee adopts a child or has a child placed with the employee for adoption. The Effective Date of Coverage shall be governed by the provisions of this Plan concerning addition of a Spouse, a newborn Child or an adopted Child, as applicable.

4.0 TERMINATION OF COVERAGE

4.1 Termination of Member Coverage

1. Events Triggering Termination: Coverage is subject to all terms and conditions of this SPD, and coverage will terminate under certain conditions described in various other places throughout this document. If coverage is not terminated under any other provision of this document, coverage for a Member shall terminate if any of the following events occur with respect to such Member:
 - a. the Subscriber or Member dies
 - b. the Member ceases to be eligible as a Subscriber or Dependent for any reason;
 - c. the Member is a Dependent Spouse that becomes legally separated from the Subscriber
 - d. the Plan terminates or the state ceases to sponsor the Plan; or
 - e. the Member's coverage is terminated "for cause," as hereinafter provided.
2. Effective date of Termination: Coverage is subject to all terms and conditions of the Plan,

and coverage will terminate under certain conditions as described in various other places throughout this document. If coverage is not terminated under any other provisions of this document, coverage for a Member shall terminate if any of the following events occur:

a. Coverage shall terminate at 12:00 midnight Central Standard Time on the date of event when:

- 1). the Subscriber or Member dies; or
- 2). the Plan terminates

3. Coverage shall terminate at 12:00 midnight Central Standard Time on the last day of the contract month in which the event occurs when:

- a. the Member ceases to be eligible as a Subscriber or Dependent for any reason; or
- b. the Member is a Dependent Spouse that becomes legally separated from the Subscriber.

4.2 Termination of a Member's Coverage For Cause

1. Concealment, Misrepresentation or Fraud: Coverage of a Subscriber or a Dependent(s) under this Plan may be terminated subject to a fifteen (15) day written notice and appeal rights as outlined in Section 4.2.3, below, for:

- a. concealment of information, misrepresentation (whether intentional or not) or fraud in obtaining coverage for a Subscriber or a Dependent(s); or
- b. concealment of information, misrepresentation (whether intentional or not) or fraud in the filing of a claim (or in causing a claim to be filed) or in the use of services or facilities.

2. Other Causes: Coverage of a Subscriber or a Dependent(s) under this Plan may be terminated subject to a thirty (30) day written notice and appeal rights as outlined in Section 4.2.3, below, for:

- a. inability, after reasonable attempts by a Plan Provider, to establish and maintain a satisfactory provider-patient relationship
- b. failure or refusal to cooperate in Coordination of Benefits, or Subrogation activities;
- c. failure to pay applicable Copayments or Coinsurance; or
- d. failure to provide information requested by the Claims Administrator for verification of continued eligibility.

3. Appeal Procedure

a. Concealment, Misrepresentation or Fraud. A Member may appeal a termination due to concealment, misrepresentation or fraud. Any such appeal must be submitted in writing, addressed to the Plan Administrator at:

Employee Benefits Division
Appeals and Medical Compliance
P.O. Box 15610
Little Rock, AR 72231-5610

In order for the appeal to be considered, it must be received in the offices of the Plan Administrator prior to the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Member at his or her last known address as provided by the Member to the Plan Administrator; or (ii) the termination effective date stated in the termination notice letter to Member.

b. Other Causes: A Member may appeal a termination due to any of the other causes outlined in Section 4.2.2. Any such appeal must be submitted in writing, to the Plan Administrator at the addresses listed above. In order for the appeal to be considered, it must be received in the offices of the Plan Administrator prior to the later of (i) thirty (30) days after a written notice of termination for cause is posted in the U. S. Mail,

addressed to the Member at his or her last known address as provided by the Member to the Plan Administrator; or (ii) the termination effective date stated in the termination notice letter to Member.

4. Effective Dates of Terminations for Cause

- a. Concealment, Misrepresentation or Fraud. Termination due to concealment, misrepresentation or fraud shall be effective upon the later of
 - (i) fifteen (15) days after a written notice of termination for cause is posted in the U. S. Mail, addressed to the Member at his or her last known address as provided by Member to the Plan Administrator; or
 - (ii) the date stated in the termination notice letter to Member.
- b. Other Causes: Termination due to any of the other causes outlined in Section 4.2.2 shall be effective upon the later of
 - (i) thirty (30) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Member at his or her last known address as provided by Member to the Plan Administrator; or
 - (ii) the date stated in the termination notice letter to Member.

4.3 Retroactive terminations. The Plan Administrator requires notification of terminations within sixty (60) days of the event. If the termination request is not received within sixty (60) days of the event, coverage for the Member will be retroactively terminated, but not more than sixty (60) days from the first of the month in which the termination request is received by the Plan Administrator. The Claims Administrator will request refunds from providers on behalf of EBD for all claims that have been paid for the dates for services past the termination date. Coverage will not be retroactively terminated if drug charges have been incurred during the requested period.

4.4 Termination of the Plan, Impact on Members: The coverage of all Members shall terminate if the Plan is terminated.

5.0 MEMBER CONTINUATION PRIVILEGES

5.1 COBRA Continuation: If Section 1001 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to the Plan, the coverage of a Member or Dependent whose coverage ends due to a Qualifying Event may be continued while the Plan remains in force subject to the terms of this section and all terms and provisions of this Plan not inconsistent with this section. See NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS on page iii.

5.2 Retirement Continuation.

1. Qualifications: An employee who terminates active employment and is covered or eligible for coverage under the Plan may continue coverage as a retiree if all of the following conditions are met:

- a. If the Employee is an active member of the: Arkansas Public Employees' Retirement System, including the members of the legislative division and the contract personnel of the Arkansas National Guard; Arkansas Teacher Retirement System; Arkansas State Highway Employees' Retirement System; Arkansas Judicial Retirement System; or Alternative Retirement Plan; and

- b. the covered Subscriber makes a timely election of continuation of coverage in accordance with Arkansas Code Annotated Section 21-5-411 as amended and the rules promulgated under this law by the EBD; or the qualified retiree declines coverage and specifies in writing that the reason for declination is the active retiree or dependents have coverage through another insurance program or group health plan at the time of retirement and later qualifies under the Special Enrollment Period;
 - c. **the Subscriber or Dependent continuing coverage is over age sixty-five (65) when the Subscriber elects coverage or later reaches age sixty-five (65), such Subscriber or Dependent must elect Medicare Part A and B; and**
 - d. the Subscriber makes the appropriate contribution required to continue the coverage from the date employment ends/date enrolled in plan.
2. Election to Enroll in Retirement Continuation. Election to participate in a retiree health benefit plan must be made with in thirty-one (31) days of notification of termination of employment or retirement.
 3. Election to Decline Retirement Continuation: Election to decline to participate in the retiree health benefit must be made with in thirty-one (31) days of notification of termination of employment or retirement and is accomplished by checking the "I Decline Coverage" box on the Enrollment Form. The election to decline coverage is final, except that a qualified retiree may later elect coverage providing the retiree declining coverage specifies in writing that the reason for declination is that the active retiree or dependents have coverage through another insurance program or group health plan at the time of retirement and the retiree later qualifies under the Special Enrollment Period. See Section 3.10 above.
 4. Termination of Retirement Continuation. The termination of continuation coverage for a retiree Subscriber and the Subscriber's Dependents is governed by Section 4.0 above.
 5. Addition of Dependents to Retirement Plan. Dependents may be added to a retiree Subscriber's coverage only as a result of a Special Enrollment Period, See Section 3.10 above.

6.0 OUT OF SERVICE AREA

Health Advantage

- 6.1 Out of Service Area Services.** Health Advantage have access to the BlueCard Program for Emergency Care or Urgent Care while outside of the Service Area (State of Arkansas). Services must be received from a Blue Cross and/or Blue Shield provider listed in the BlueCard Traditional Network. Claims are billed with the XCH prefix and the Member's ID number through the Local health plan and routed electronically to Health Advantage. Medical Services other than Emergency Care or Urgent Care through the BlueCard Program must first be authorized by the Member's Primary Care Physician and approved by Health Advantage.

Effective October 01, 2003, Health Advantage will discontinue the Away From Home Care Guest Membership Program. Members working or living outside the services area (State of Arkansas) for more than 90 days will not be able to apply for a Guest Membership in a local HMO.

Effective October 01, 2003, Health Advantage Members that live, work or are on extended travel outside the Service Area for more than 90 days may be eligible for a temporary Out

of Area Classification. If approved by Health Advantage, the member uses his/her Health Advantage ID Card to access services covered by Health Advantage on the Member's Group Health Plan. Services are covered at the In-Network benefit level when provided by a Blue Cross and /or Blue Shield provider listed in the BlueCard Traditional Network. Claims are billed with the XCH prefix and the Member's ID number through the Local health plan and routed electronically to Health Advantage for payment. The Member's out of pocket expenses are limited to the Member's In-Network Deductible, Copayment, and/or Coinsurance.

Members eligible for this benefit are:

- Subscriber on Extended Business. Subscribers that travel outside the State of Arkansas for more than ninety (90) days but less than eighteen (18) days are eligible for a temporary Out of Area Classification not to exceed 180 days. Only one renewal per year is allowed.
- Students Attending School Outside the Service Area. Dependent Students attending school Outside the State of Arkansas for at least ninety (90) consecutive days are eligible for an Out of Area Classification for the school year. Renewal is required at least annually.
- Dependents Residing Outside the Service Area. Dependents (spouse or child) residing Outside the State of Arkansas for at least ninety (90) consecutive days are eligible for an Out of Area Classification. Renewal is required at least annually.

The Subscriber must complete the application requesting a temporary Out of Area Classification for the eligible family member. The completed must be either faxed to 501-301-6869 or mailed to: Health Advantage Membership, P.O. Box 8069, Little Rock, AR 72203-8069. If approved, the Member will be sent an ID card and benefit materials to use when accessing covered services in the area they are residing. The maximum time for which the Out of Area Classification can be assigned is six months for eligible Subscribers and one year for eligible dependents. A completed application is required for each renewal period.

To locate the nearest participation BlueCard Traditional Network provider, Members may go to www.bcbs.com or call 1-800-810-2583 (BLUE). For more information on the BlueCard Program and to print a copy of the Application of Out of Area Classification, Members may go to www.HealthAdvantage-hmo.com or contact Customer Services at 1-800-843-1329.

NovaSys Health

- 6.2 Out of Service Area Services. NovaSys Health Members have access to The NovaSys Health National Network (through Beech Street Corporation) for Emergency Care or Urgent Care while outside of the Service Area (NovaSys Health Regional Network). Services must be received from a Beech Street Corporation provider listed in the Beech Street Corporation

Network. Claims are billed with the Member's ID number and routed to NovaSys Health. Medical Services other than Emergency Care or Urgent Care must first be authorized by the Member's Primary Care Physician and approved by NovaSys Health. To initiate this process, contact NovaSys Health, Customer Service at 1-888-870-8103.

NovaSys Health Members that live, work or who are on extended travel outside the Service Area for more than 90 days may be eligible for a temporary Out of Area Classification. If approved by

NovaSys Health, the member uses his/her NovaSys Health ID Card to access services covered by NovaSys Health on the Member's Group Health Plan. Services are covered at the In-Network benefit level when provided by a Beech Street Corporation provider listed in the Beech Street Corporation Network when services are delivered outside the NovaSys Health Regional Network. Members must present their ID card at the time of service. Claims are billed with the Member's ID number and routed to NovaSys Health for payment. The Member's out of pocket expenses are limited to the Member's In-Network Deductible, Copayment, and/or Coinsurance.

Members eligible for this benefit are:

- Members or Covered Dependents on Extended Business. Members that travel outside the State of Arkansas for more than ninety (90) days but less than one hundred eighty (180) days are eligible for a temporary Out of Area Classification not to exceed 180 days. Only one renewal per year is allowed.

- Student Covered Dependents Attending School Outside the Service Area. Dependent Students attending school Outside the NovaSys Health Regional Network area for at least ninety (90) consecutive days are eligible for an Out of Area Classification for the school year. Renewal is required at least annually.

- Dependents Residing Outside the Service Area. Dependents (spouse or child) residing Outside the NovaSys Health Regional Network area for at least ninety (90) consecutive days are eligible for an Out of Area Classification. Renewal is required at least annually.

The Member must complete the application requesting a temporary Out of Area Classification for the eligible family member. The completed form must be either faxed to 501-219-4455 or mailed to: NovaSys Health Customer Service, P.O. Box 25310, Little Rock, AR 72221-25310. If approved, the Member will be sent an ID card and benefit materials to use when accessing covered services in the area they are residing. The maximum time for which the Out of Area Classification can be assigned is six months for eligible Subscribers and one year for eligible dependents. A completed application is required for each renewal period.

Under the following circumstances, the higher in-Network payment will be made for certain non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking, or if the medically necessary procedure is unavailable through in network providers, within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Ancillary services by a non-Network Provider at an in-Network facility. (Generally limited to hospital based providers, Pathology, Radiology, Anesthesiology, or when services associated with patient care are sent outside the facility)

Additional information about this option, as well as a list of Participating Providers, will be given to Plan Participants, at no cost, and updated as needed. To locate the nearest participating Beech Street Corporation Network provider, Members may go to www.beechstreet.com or call 1-888-870-8103. For more information on the NovaSys Health Network and to print a copy of the Application of Out of Area Classification, Members may go to www.novasyshealth.com or contact Customer Service at 1-888-870-8103.

QualChoice

6.3 Out of Service Area Services: When you are traveling out of our Service Area for some purpose other than the receipt of medical care, or are a covered dependent student between the age of nineteen (19) and twenty-seven (27) residing out of the Service Area, benefits may be provided for illness or injury if the following criteria are met:

1. You have selected a Network Primary Care Physician.
2. The condition is one of rapid onset, or is the result of an injury;
3. Return to the QualChoice Service Area to receive treatment from your Network Primary Care Physician is not feasible;
4. The treatment is determined to be Medically Necessary;
5. QualChoice is notified prior to inpatient admission, surgery, consultation, or testing, after the medical screening is performed at an emergency room, or as soon as you or a person acting on your behalf is physically able to do so; and
6. All claims and proof of service are submitted in writing within 180 days after the date on the original bill.

These services may be subject to the process outlined below in Procedures for Pre-authorization described in attachment B. (See section ii for Differences in HMO and POS).

7.0 OTHER HEALTH PLANS AND BENEFIT PROGRAMS

7.1 Coordination of Benefits: Coordination of Benefits ("COB") applies when a Member has coverage under more than one Health Benefit Plan.

1. Definitions: For purposes of Section 7.0 only, the following words and phrases shall have the following meanings:
 - a. "Allowable Expenses" means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Health Benefit Plans covering the person for whom claim is made. When a Health Benefit Plan (including this Plan) provides benefits in the form of coverage for services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.
 - b. "Health Benefit Plan" means any of the following (including this Plan) which provide coverage for medical care or treatment:
 - (1). Coverage under government programs, including Medicare, required or provided by any statute unless coordination of benefits with any such program is forbidden by law.

If a member is eligible for Medicare the member must take Medicare Part A and B. The premium will not reduce unless the member has both Part A and Part B. The plan will pay as if the member had Part B, regardless of whether he/she has Part B.

- (2) Group coverage (other than group automobile insurance) or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis, including any prepayment coverage, group practice basis or individual practice coverage or any coverage for students which is sponsored

by, or provided through a school or other educational institution above the high school level.

The term "Health Benefit Plan" shall be construed separately with respect to:

- (1) each policy, contract or other arrangement for benefits or services: and
 - (2) that portion of any such policy, contract or other arrangement which reserves the right to take the benefits of other Health Benefit Plans into consideration in determining its benefits and that portion which does not apply.
2. The Claims Administrator and EBD shall have the right to coordinate benefits between this Plan and any other Health Benefit Plan covering the Member.

The rules establishing the order of benefit determination between this Plan and any other Health Benefit Plan covering the Member on whose behalf a claim is made are as follows:

- a. The benefits of a Health Benefit Plan which does not have a "coordination of benefits with other health plans" provision shall in all cases be determined and applied to claims before the benefits of this Plan.
 - b. If according to the rules set forth in Subsection 3 of this Section, the benefits of another Health Benefit Plan that contains a provision coordinating its benefits with this Plan would be determined and applied, before the benefits of this Plan have been determined and applied, the benefits of such other Health Benefit Plan will be considered before the determination of benefits under this Plan. Under no circumstances shall benefits payable and paid under this Plan exceed the total charge for services a Member received.
3. Order of Benefit Determination: The order of benefit determination as to a Member's claim shall be as follows:
- a. The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent shall be determined and applied before the benefits of a plan which covers such person as a dependent. (By way of example only, if one Plan [Plan A] covers a Member as employee and the other plan [Plan B] covers the Member as a dependent of an employee [Plan B], then Plan A is deemed "primary" and Plan A's benefits will be applied and paid before any consideration of Plan B.)
 - b. The benefits of a plan which covers the person on whose expenses a claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either plan does not have the provisions of this paragraph regarding dependents, which results either in each plan determining its benefits before the other, or each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of benefits; except that in the case of a person for whom claim is made as a dependent Child:
 - (1) When the parents are divorced or separated and there is a court decree which fixes financial responsibility on one of the parents for the medical, dental, or other health care expenses with respect to the Child, the benefits of a plan which covers the Child

as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the Child as a dependent Child.

- (2) When the parents are separated or divorced and the parent with custody of the Child has not remarried, if there is no court decree fixing financial responsibility on one of the parents for the medical, dental or other health care expense with respect to the Child, the benefits of a plan which covers the Child as a dependent of the parent with custody of the Child will be determined before the benefits of a plan which covers the Child as a dependent of the parent without custody.
 - (3) When the parents are divorced and the parent with custody of the Child has remarried, if there is no court decree fixing financial responsibility on one parent for the medical, dental or other health care expense with respect to the Child, the benefits of a plan which covers the Child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a dependent of the step-parent, and the benefits of a plan which covers that Child as a dependent of the step-parent will be determined before the benefits of a plan which covers that Child as a dependent of the parent without custody.
 - c. When paragraphs (1) and (2) above do not apply so as to establish an order of benefits determination, the benefits of a plan which has covered the person on whose expenses a claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, except that:
 - (1) The benefits of a plan covering the person on whose expenses claim is based as a laid-off or retired employee or as a dependent of such person shall be determined after the benefits of any other plan covering such person as an employee other than as a laid-off or retired employee or a dependent of such person, and
 - (2) If either plan does not have a provision regarding laid-off or retired employees, and, as a result, each plan determines its benefits after the other, then the provisions of subparagraph (1) of this paragraph do not apply.
 4. Medicare Primary End Stage Renal Disease: If a member is effective with Medicare due to End Stage Renal Disease and has satisfied the required waiting period of thirty (30) months, Medicare will become the primary payer for treatments related to renal disease only. The member must also have Medicare Part B for coverage of services provided on an outpatient basis.
- 7.2 Military Benefits: Services and benefits for military service-connected disabilities to which a Member is legally entitled and for which facilities are reasonably available shall in all cases be provided before the benefits of this Plan.
- 7.3 Claims Administrator's and EBD's Right to Member Coverage Information: The Claims Administrators and EBD may, subject to applicable confidentiality requirements set forth in this SPD, release to or obtain from any insurance company or other organization necessary information under this provision. Any Member claiming benefits under this Plan must furnish to the Claims Administrator and EBD promptly upon request all information deemed necessary by it to implement this provision. If a Member fails or refuses to provide information requested, the Claims Administrator and EBD shall be entitled to withhold benefits or payments otherwise

due under their Plan. See the Employee Benefits Division Notices of Privacy Practices in Section i.

- 7.4 Claims Administrator's and EBD's Right to Overpayments: Whenever payments have been made by the Claims Administrator with respect to Allowable Expenses in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Plan, the Claims Administrator shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as the Claims Administrator shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance company or companies; or any other organization or organizations to which such payments were made.
- 7.5 Workers' Compensation: There are no benefits under this Plan for treatment of any compensable injury, as defined by the Workers' Compensation Law, regardless of whether or not the Member timely filed a claim for workers' compensation benefits.

The Claims Administrator will presume that if the Member makes a claim for worker's compensation benefits, the injury for which the Member makes any such claim is a compensable injury under the Workers' Compensation Law, and therefore, the Plan Administrator will not be liable for payment of any benefits as to such a claim, unless there is a specific finding by the full Workers' Compensation Commission, not overturned on appeal, that the Member's injury was not a compensable injury. The foregoing presumption of non-coverage under this Plan also applies to any case in which the Member's workers' compensation benefits claim is settled by joint petition or otherwise, in which case no benefits will be paid by this plan with respect to such a claim, regardless of the settlement amount.

Nor will the Plan pay benefits for injury or illness for which the Member receives any benefits under the Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, regardless of any limitations in scope or coverage amount which may apply to the Member's benefits claim under such laws.

In the event that the Plan pays any claim of the Member for benefits under this Plan, and subsequently learns that the Member has filed a claim for workers' compensation benefits as to such claim, or that the Member has settled a workers' compensation claim with any workers' compensation carrier, or has otherwise received any amount toward payment of such a claim under the Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, the Member agrees to reimburse the Plan to the full extent of its payments on such claim.

- 7.6 Member's Cooperation: Each Member shall complete and submit to the Claims Administrator and EBD such consents, releases, assignments and other documents as may be requested by the Claims Administrator or EBD in order to obtain or assure reimbursement under Medicare or workers' compensation. Any Member who fails to so cooperate will be liable for and agrees to pay to the Claims Administrator or EBD the amount of funds the Claims Administrator or EBD had to expend as a result of such failure to cooperate.
- 7.7 Acts of Third Parties (Subrogation): If a Member is injured by a third party, the Plan is subrogated to such rights the Member may have against such third party to the extent of the services or benefits provided. The Member must cooperate fully with the Claims Administrator in its efforts to collect from the third party, and if the Member fails to do so, the Claims Administrator and

EBD shall be entitled to withhold coverage of benefits, services, payments or credits due under this Plan.

8.0 MEMBER RIGHTS AND RESPONSIBILITIES

- 8.1 Member Complaints: Member Complaint and Appeal Process. Any problem or claim between a Member and Claims Administrator must be dealt with through Claims Administrators' Member Complaint and Appeal Process. Complaints may concern non-medical or medical aspects of care as well as the terms of this Plan, including its breach or termination. A copy of the Claims Administrator's Member Complaint and Appeal Process is incorporated in this Plan as Attachment A. Termination of coverage "For Cause" is subject to the appeal procedures set forth in Section 4.2.3.
- 8.2 Primary Care Physician (PCP) Selection. Members MUST select and are expected to maintain a patient physician relationship with a PCP. The PCP selected must be a physician listed in the Claims Administrator's Provider Directory specific to the Claims Administrator you have selected as a PCP and accepting new patients. Members should call the appropriate Claims Administrator's Customer Service to select a PCP or change their PCP. PCP requests received by the 31st of the month will be effective the first of the next month. If a Member changes a PCP, any outstanding Referral the Member had received from a previous PCP terminates, unless the new PCP re-authorizes such Referral. **QualChoice no longer requires female enrollees age sixteen (16) years or older to select a Network Primary Care Obstetrician/Gynecologist Physician**
- 8.3 Continuity of Treatment Upon Termination of a Physician or Provider
1. The Claims Administrator shall provide reasonable notice to a Member of the impending termination of a Plan Physician or Plan Provider who is currently treating such Member.
 2. If the Claims Administrator's contract with a Plan Physician or a Plan Provider is terminated, Members being treated at the time of termination by such Plan Physician or Plan Provider for a current episode of an acute condition may continue coverage under this Plan for such treatment. The Plan Administrator's obligation to reimburse a terminated Plan Physician or Plan Provider shall not extend beyond ninety (90) days or to the end of the current episode of treatment, whichever comes first, from the effective date of the former Plan Physician's or Plan Provider's termination.
 3. In order to request continuation of treatment, in accordance with Section 8.3, a Member must submit a written request to the Claims Administrator. See Section 10.5.
- 8.4 Out of Network Referrals. If Medically Necessary Covered Services are not available through Plan Physicians or Plan Providers, the Claims Administrator, on the request of a Plan Physician or Plan Provider made within a reasonable period prior to receiving the service, shall approve coverage for Referral to a non-plan Physician or provider at the Allowable Charge or an agreed rate. The non-plan Physician or Provider may bill the Member charges in excess of the Allowable Charge. Claims Administrator's denials may be appealed to EBD for a final decision.
- 8.5 A Member has a right to:
1. Information about the Plan and the Plan Administrator;
 2. Information about the Claims Administrator, its services, its practitioners and providers, and members rights and responsibilities;
 3. Access to a Plan Physician;

4. An explanation of benefits, as appropriate;
5. Be treated with respect and recognition of his/her dignity and right to privacy;
6. Confidential treatment of medical information;
7. Participate with practitioners in decision making regarding his/her health care;
8. A candid discussion of appropriate or medically necessary treatment options for his/her conditions, regardless of cost or benefit coverage;
9. Change Primary Care Physicians;
10. Voice complaints or appeals about Claims Administrators or Plan Providers; and
11. Provide, to the extent possible, information that practitioners and providers need in order to care for him/her.

Furthermore, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice of Privacy Practices, see section (i) of this book. This Plan and the Plan Sponsor, will not use or further disclose information that is protected ("protected health information") by HIPAA except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

8.6 A Member agrees to:

1. become familiar with the requirements and procedures of his/her individual Claims Administrator;
2. present Member ID Card to the health care provider when seeking care;
3. select a Primary Care Physician ;
4. maintain health levels by "living a healthy life style";
5. coordinate all health care through the Primary Care Physician;
6. provide information to health care providers to assist them in the care needed to achieve health outcomes;
7. follow all instructions given by health care providers to achieve maximum benefits of the care, including instructions given in Case Management and Disease Management programs;
8. meet all Copayment and Coinsurance obligations;
9. notify the EBD of any status change;
10. obtain all non emergency care through Plan Providers;
11. communicate any complaint or grievance immediately to the Claims Administrator;
12. ensure all claims for services provided by non Plan Providers are filed within sixty (60) days;
13. notify the Claims Administrator and EBD when any Member in the Member's family is covered by another group health plan; and
14. cooperate fully in the Claims Administrator's subrogation process to collect for services that are the legal responsibility of a third party.

Members may choose to utilize their out-of-network option if enrolled in a POS Plan. However, if this benefit is utilized, the member will have increased financial responsibility. (See section ii for differences in HMO and POS)

8.7 Utilization Management. The Claims Administrators for Arkansas State and Public School Employees provide Utilization Management (UM) services to Members using nationally accepted utilization management guidelines and internally developed reimbursement guidelines. In making coverage decisions the Claims Administrators apply these UM guidelines and reimbursement guidelines to information provided by the member's primary care physician, any specialist(s) involved in the care, and the member's medical records. In order to obtain coverage for "out of network" care, in an HMO, authorization for coverage must be requested by the physician and approved before the service is provided, except in an emergency. See section 8.4 above, out of network referrals. The Member's physician may request review of the criteria used for decision making in writing. Claims Administrators' Medical Directors are available to discuss the criteria with the Member's physician.

9.0 NOTICE OF PHYSICIAN INCENTIVES

Claims Administrators regularly enter into contracts with Plan Physicians to provide Professional Services to Members. The purpose of this Section 9.0 is to provide Members information about the incentive arrangements between Claims Administrators and Plan Physicians.

9.1 Definitions: The following definitions are used in this Section 9.0:

1. "Negotiated Fee-For-Service" means a pre-determined amount for each service a Plan Provider provides. Plan Providers and the Claims Administrators agree to the Negotiated Fee-For-Service. This amount may be different from the amount the Plan Provider usually receives from other payers.
2. "Capitation" means a set dollar payment per patient per unit of time (usually per month) paid to a Physician to cover a specified set of services and administrative costs without regard to the actual number of services provided. Services to which Capitation may be applied including a Physician's own services, referral services or other services. At present, the Claims Administrators' Capitation is limited to services provided directly by Plan Physicians, i.e. there is no Capitation for referral services.

9.2 Claims Administrator Plan Provider Incentives: Claims Administrators may pay providers using both Capitation and Negotiated Fee-For-Service arrangements. At the end of each year, if medical costs are below what was budgeted by agreement between the Claims Administrator and participating Plan Providers, then the Claims Administrator, Plan Physicians and Plan Hospitals share in the surplus, based upon a settlement formula described in the applicable provider contracts.

9.3 Individual Physician's Incentives Are Not Tied to Referral Practices: An individual Plan Physician does not make or lose money under his or her contract with the Claims Administrator based upon referral practices. Referral practices may be evaluated as part of an overall reimbursement plan for groups of Plan Physicians, and thus, referral practices could indirectly affect the level of reimbursement for a group of Plan Physicians in some cases. For example, if, as a group, all Plan Physicians in a given geographic area have fewer expenses than expected, they may share in any surplus amount. If, however, the Plan Physicians incur more expenses than the budgeted amount, they are not required to "make up" the difference; the Claims Administrator would absorb this loss.

9.4 Incentive Arrangement Subject to Change: The incentive arrangements described here concern the provider contracts in place and regularly used by the Claims Administrators at the time

this SPD was issued. Because of the rapid pace of change in health care financing in today's marketplace, physician negotiating positions, regulatory changes, or other developments, the precise content of the Claims Administrators' provider reimbursement and incentive plans may change significantly in the future.

- 9.5 For Further Information: A Member desiring further information about provider incentives or seeking updated information after the date this SPD is issued, should contact the Claims Administrator. See Section 10.5 of this SPD.

10.0 GENERAL PROVISIONS

- 10.1 Entire Summary Plan Description. This Summary Plan Description (SPD), including any attachments and the individual applications, if any, of the Members set forth a description of the benefits, conditions, limitations and exclusions of the Plan, as of the Member's effective date and supersedes all prior benefits certificates, evidences of coverage or summary plan descriptions issued to the Member by the Plan.

- 10.2 Changes to Plan: EBD, as Plan Administrator, reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. Amendments to the Plan may occur in any or all parts of the Plan, including benefits coverage, maximums, copayments, exclusions, limitations, definitions and eligibility. If the Plan is amended, EBD will give thirty (30) days written notice to the Subscribers and the amendment will go into effect on the date fixed in the notice.

No agent or employee of EBD or the Claims Administrator may change or modify any benefit, term, condition, limitation or exclusion of Plan. Any change or amendment must be in writing and signed by Executive Director of EBD.

- 10.3 Authorization to Release Member Records. The Member consents to and authorizes a Physician, Hospital, Skilled Nursing Facility, Substance Abuse center or other Plan Provider of care to release to the Claims Administrator and EBD and to permit the examination and copying of any portion of the Member's medical records, claims or related information, when requested by the Claims Administrator or EBD.

- 10.4 Notice of Claim. It is not expected that a Member will make payment, other than required Copayments and Coinsurance, for any coverage provided hereunder. However, if such payments are made, a claim for reimbursement shall be made by the Member. Such claim shall be allowed only if notice of claim is made to the Claims Administrator within one hundred eighty (180) days from the date on which covered expenses were first incurred, unless it shall be shown not to have been reasonably possible to give notice within the time limit, and that notice was furnished as soon as was reasonably possible. Within forty-five (45) days of receipt of a written notice of claim, the Claims Administrator shall process the claim unless additional information is needed. If additional information is requested, the Claims Administrator will act on the claim no later than thirty (30) days after the Claims Administrator receives such additional information. If a claim is paid to an Out-of-Network provider, the member will be responsible for the difference between the billed charges and Allowable Charges. (Out-of-Network claims will not be covered at the in-network benefit level without the prior written approval by the Claims Administrator). Any claim denial will be made in writing and contain the reasons for the denial. A Member may obtain a review of the denial by following the procedures set out in the Complaint and Appeal Process (Attachment A) of this SPD.

10.5 Notice. Any notice to the Claims Administrator under this SPD may be given by United States mail, first class, postage prepaid, addressed as follows:

If to Health Advantage:

HMO Partners, Inc.
d/b/a Health Advantage
Post Office Box 8069
Little Rock, Arkansas 72203-8069
(501) 378-2437
800-482-8416
or

such other address as Health Advantage may hereafter specify by notice to Members.
If to a Member, at the last address known to Health Advantage, or;

If to NovaSys Health:

NovaSys Health
P.O. Box 25230
Little Rock, Arkansas 72221
(501) 975-4853
800-294-3557
or

such other address as NovaSys Health may hereafter specify by notice to Members.
If to a member, at the last address known to NovaSys Health; or

If to QualChoice:

QualChoice of Arkansas, Inc.
10825 Financial Parkway, Suite 400
Little Rock, Arkansas 72211
(501) 228-7111
(800) 235-7111
or

such other address as QualChoice may hereafter specify by notice to Members. If to a Member, at the last address known to QualChoice.

- 10.6 Funding of Plan. EBD, as Plan Administrator, is responsible for providing funding for Plan benefits. In the event EBD fails to provide the necessary funds, The Claims Administrators may delay payment of claims until it receives such funds from EBD.
- 10.7 Interpretation of this SPD. The laws of the State of Arkansas shall be applied to interpretations of this SPD. If the SPD contains any provision not in conformity with state law, the SPD shall not be rendered invalid but shall be construed and applied as if it were in full compliance with said law, subject only to any Federal Law or Regulation which may preempt state law.
- 10.8 Assignment. No assignment of benefits under this SPD shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the provider of service or to the Member unless otherwise instructed by the Plan Administrator, EBD.
- 10.9 Clerical Error. Clerical error, whether of the Plan or Claims Administrator, in keeping any records

pertaining to the coverage hereunder will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

- 10.10 **Incontestability.** In the absence of fraud, all statements made by a Member are considered representations and not warranties. During the first two (2) years, coverage can be terminated or voided for misrepresentation contained in a written application. After two (2) years, coverage can be voided based on a misrepresentation on an application only if the misrepresentation was fraudulent. A copy of the written application must have been furnished to the Member if the terms of the application or enrollment form are to be applied. Coverage may be terminated at any time based on concealment, misrepresentation or fraud in connection with any claim or in the use of services or facilities, as set forth in Section 4.2.1.b.
- 10.11 **Limitation of Liability.** Liability for any errors or omissions by the Claims Administrators (or its officers, directors, employees or agents) in the administration of the Plan, or in the performance of any duty or responsibility contemplated by the Plan, shall be limited to the maximum benefits which should have been paid under the Plan had the errors or omissions not occurred.
- 10.12 **Legal Action.** Prior to initiating legal action, a Member must exercise his or her rights to appeal in accordance with the Complaint and appeals Process set out in Attachment A of this SPD.

11.0 GLOSSARY OF TERMS

- 11.1 ***“Administrative Services Agreement”*** is, a signed agreement between EBD and the Claims Administrator to serve as the Claims Administrator and to administer the benefits according to the terms, conditions, limitations and exclusions set out in this SPD.
- 11.2 ***“Allowable Charge”*** means, when used in connection with services or supplies covered under this SPD, the amount deemed by the Claims Administrator, in its sole discretion, to be reasonable. The Claims Administrators’ customary allowance is the basic Allowable Charge. However, this Allowable Charge may vary, given the facts of the case and the opinion of the Medical Director of the Claims Administrator.
- In the case of multiple surgeries performed through the same incision or in the same operative area for which there is not a unique single Allowable Charge, the Allowable Charge for all procedures combined will be an amount equal to the highest single procedure Allowable Charge of the procedures performed plus one-half of the Allowable Charge for each of the other procedures.
- 11.3 ***“Annual Coinsurance Limit”*** means the maximum amount of coinsurance payments a Member is required to make in connection with Covered Services or supplies in a Contract Year. Copayments and amounts a Member may have to pay in excess of contract benefit limits do not contribute to the Annual Coinsurance Limit.
- 11.4 ***“Annual Open Enrollment Period”*** means the time period annually, during the month of August, when Arkansas Public School employees who are eligible for coverage may enroll in the Plan. During the Annual Enrollment Period, employees covered in the Plan may change their coverage, and that of their covered dependents, to any one of the carriers offering the Plan. Enrollments and coverage changes made during the Annual Enrollment Period become effective on the first of October.
- 11.5 ***“Behavioral Health Care Provider”*** means a psychiatrist, psychologist, Hospital or health care

professional or counselor specializing or engaging primarily in offering Mental Health or substance Abuse treatment or counseling. A Primary Care Physician is not a Behavioral Health Care Provider. **(Behavioral Health Care is not a covered benefit under this section of this SPD. Behavioral Health Care is provided through CorpHealth and outlined in a separate section of this SPD).** Claims for detoxification and medical stabilization will be paid under the medical benefits of this SPD.

- 11.6 “*Case Management*” means a process in which the Claims Administrators’ staff provide information and assistance to a Member and the Member’s treating physician(s) about cost-effective treatment alternatives from which the Member and the Member’s physician(s) may choose, including, where deemed appropriate by the Member’s physician(s), outpatient or home care settings.
- 11.7 “*Chemotherapy*” means chemotherapy for the treatment of a malignant disease by chemical agents that affect the causative organism unfavorably. High Dose Chemotherapy is chemotherapy for malignant disease several times higher than the standard dose (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., Granulocyte Colony-Stimulating Factor, Granulocyte-Macrophage Colony-Stimulating Factor, re-infusion of stem cells, re-infusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any patient who received this high dose chemotherapy, to prevent life-threatening complications of the chemotherapy on the patient’s own progenitor blood cells.
- 11.8 “*Child*” means a Subscriber’s natural Child, legally adopted Child or Stepchild. “Child” also means a Child that has been placed with the Subscriber for adoption. “Child” also means a Child for whom the Subscriber or the Subscriber’s spouse must provide medical Child support pursuant to a court order or a Child for whom the Subscriber has been court appointed the guardian.
- 11.9 “*Claims Administrator*” means Health Advantage, QualChoice, CorpHealth, and NMHC Rx. As the Claims Administrators, QualChoice, Health Advantage, CorpHealth and NMHC Rx have authority and full discretion to determine all questions arising in connection with coverage under the Plan, including interpretation of Plan language, and findings of fact with regard to any such questions. The actions, determinations and interpretations of QualChoice, Health Advantage and APCS acting on behalf of the Plan within the scope of this authority shall be conclusive and binding on the Plan and the Member, subject to the Complaint and Appeal Process set out in Attachment A.
- 11.10 “*Coinurance*” means the percentage of Allowable Charges for Covered Services for which the Member is responsible. Please Note: Because the contract between the Claims Administrators and a Plan Provider may include risk sharing arrangements that may involve a portion of the Plan Provider’s compensation or fees being withheld at the time the claim is paid, the actual Coinsurance percentage for which a Member is responsible on any given claim may be higher than the percentages stated in Attachment C to this SPD. The actual coinsurance percentage is dependent upon the year-end settlement or periodic adjustments between the Plan Provider and the Claims Administrator.
- 11.11 “*Contract Year*” means the twelve consecutive month period commencing on the Group Contract effective date and ending on the day before the anniversary of that effective date.
- 11.12 “*Controlled Substance*” means a Toxic Inhalant or a substance designated as a controlled

substance in the Arkansas Code.

- 11.13 “*Copayment*” means the amount required to be paid a Plan Physician or other Plan Provider by or on behalf of a Member in connection with the service set forth in the Schedule of Benefits, Attachment B.
- 11.14 “*Cosmetic Services*” means any treatment or corrective surgical procedure performed to reshape structures of the body in order to alter the individual’s appearance or to alter the manifestation of the aging process. Breast augmentation, mastopexy, breast reduction for cosmetic reasons, otoplasty, rhinoplasty, collagen injection and scar reversals are examples of Cosmetic Services. Cosmetic Services also includes any procedure required to correct complications caused by or arising from prior Cosmetic Services. Cosmetic Services do not include the following services in connection with a mastectomy resulting from cancer: (a) reconstruction of the breast on which the cancer-related surgery has been performed, and (b) surgery to reconstruct the other breast to produce a symmetrical appearance. The following procedures performed on a child under twelve (12) years of age are not considered Cosmetic Services: correction of a cleft palate or hair lip, removal of a port-wine stain on the face, correction of a congenital abnormality.
- 11.15 “*Covered Services*” means services and benefits for which a Member is entitled to coverage under the terms of this SPD.
- 11.16 “*Custodial Care*” means care rendered to a Member
- (1) who is disabled mentally or physically and such disability is expected to continue and be prolonged, and
 - (2) who requires a protected, monitored, or controlled environment whether in an institution or in a home, and
 - (3) who requires assistance to support the essentials of daily living, and
 - (4) who is not under active and specific medical, surgical, or psychiatric treatment outside the protected, monitored, or controlled environment.
- A custodial determination is not precluded by the fact that a Member is under the care of a supervision or attending Physician and that services are being ordered or prescribed to support and generally maintain the Member’s condition, or provide for the Member’s comfort, or ensure the manageability of the Member. Further, a Custodial Care determination is not precluded because the ordered and prescribed services and supplies are being provided by a registered or licensed practical or vocational nurse or the ordered and prescribed services and supplies are being performed in a Hospital, Nursing Home, a Skilled Nursing Facility, an extended care facility or in the home. The determination of Custodial Care in no way implies that the care being rendered is not required by the Member; it only means that it is the kind of care that is not covered under this SPD.
- 11.17 “*Dependent*” means any member of a Subscriber’s family who meets the eligibility requirements of Section 2.0, who is enrolled in the Group, and for whom EBD has received premium.
- 11.18 “*Diabetes Self-Management Training*” means instruction, including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purpose of which is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education

Program as developed by the American Diabetes Association.

- 11.19 “*Dietary and Nutritional Services*” means the education, counseling, or training of a Member (including printed material) regarding:
- (1) diet;
 - (2) regulation or management of diet; or
 - (3) the assessment or management of nutrition.
- 11.20 “*Disease Management*” means a coordinated, disease-specific educational program that seeks to provide access to information and benefit management for Members and providers regarding possible ways to reduce morbidity from preventable complications. Disease Management is not medical advice or services, nor a substitute for treatment, advice or services of the Member’s treating physician(s).
- 11.21 “*Durable Medical Equipment*” means equipment which, in the absence of illness or injury, is of no medical value to the Member including but not limited to oxygen equipment, manual wheelchairs, crutches, etc. and is provided as a result of Medical Necessity, not for the convenience of the Member or any other person.
- 11.22 “*EBD*” means Employee Benefits Division for the State of Arkansas Department of Finance and Administration. The EBD consists of an Executive Director and staff employed to provide general administrative support and supervision, which will ensure the operation of the Arkansas Public school Employee Insurance Program in accordance with the laws set forth by Act 1280 of 1999, as amended.
- 11.23 “*Emergency Care*” means health care services required to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that a condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in
- (1) placing the patient’s health in serious jeopardy;
 - (2) serious impairment to bodily functions; or
 - (3) serious dysfunction of any bodily organ or part.
- 11.24 “*Employer*” means an Arkansas Public School System, Co-ops or Charter Schools.
- 11.25 “*Experimental/Investigational*” means any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical treatment of the condition being treated or deemed to be experimental or investigational by the Claims Administrator, under the criteria outlined below. The Claims Administrator shall have full discretion to determine whether a drug, device or medical treatment is experimental or investigational. Any drug, device or medical treatment may be deemed experimental or investigational, in the Claims Administrators’ discretion, if:
1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has not been announced to the public at the time the drug or device is furnished; or
 2. The drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by

the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or

3. Reliable Evidence (as defined below) shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable Evidence (as defined below), regarding the drug, device or medical treatment or procedure shows that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
5. Reliable Evidence (as defined below) shows that, at the time a claim is presented for coverage of any drug, device, or medical treatment or procedure, the evidence is inconclusive regarding its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment. Evidence will be deemed inconclusive if reliable evidence (as defined below) shows no firm medical consensus or majority opinion either supports or denies use of the drug, device or medical treatment or procedure for a particular condition or disease; or
6. Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that it should not be used as a first line therapy for a particular condition or disease; or
7. Reliable Evidence (as defined below) is that the drug, device or medical treatment or procedure is experimental or investigational or is not safe or effective.

"Reliable Evidence" shall mean only the following sources:

- (a) the patient's medical records or other information from the treating Physician(s) or from a consultant(s) regarding the patient's medical history, treatment or condition;
- (b) the written protocol(s) under which the drug, device, treatment or procedure is provided to the patient;
- (c) any consent document the patient has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
- (d) published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, treatment or procedure at issue as applied to the injury, illness or condition at issue;
- (e) the written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure; or
- (f) the written opinion of experts engaged by the Claims Administrator to review the patient's medical history, treatment and condition, and to advise on the toxicity, safety, efficacy or efficacy as compared with the standard means of treatment, of the drug, device, medical treatment or procedure at issue.

11.26 *"Full-Time Employment"* means a full-time, active employee, holding a job with an Arkansas Public School System, working 900 hours or 720 hours for bus drivers per year.

- 11.27 “*Group*” means Arkansas Public School Employees Insurance Plan.
- 11.28 “*Home Health Agency*” means an organization, licensed by appropriate regulatory authority, which has entered into an agreement with the Claims Administrator to render home health services to Members.
- 11.29 “*Hospice*” means an organization or agency, licensed by appropriate regulatory authority and certified by Medicare as a supplier of Hospice Care, which has entered into an agreement with the Claims Administrator to render Hospice Care to Members.
- 11.30 “*Hospice Care*” means services provided for pain relief, symptom management and supportive services to terminally ill Members and their families.
- 11.31 “*Hospital*” means an acute general care Hospital, and a Rehabilitation Hospital licensed as such by the appropriate state agency. Unless required by applicable law or approved by the Claims Administrator, Hospitals owned or operated by state or federal agencies, convalescent homes or Hospitals, homes for the aged, sanitariums, long term care facilities, infirmaries, or any institution operated mainly for treatment of long-term chronic diseases are not included in this definition. Hospitalization for behavioral health or substance abuse is not covered under your physical health plan but under your behavioral health plan provided by CorpHealth. For information concerning behavioral health or substance abuse please see the behavioral health section of this SPD or contact CorpHealth at 1-866-378-1645.
- 11.32 “*Hospital Services*” (except as expressly limited or excluded in this SPD) means those Medically Necessary services which are (1) generally and customarily provided by acute care general hospitals, and (2) prescribed, directed or authorized by the Primary Care Physician; and (3) performed or provided by a Hospital. **Services provided by psychiatric facilities are covered only by CorpHealth and require Prior-authorization. Please see the behavioral health section of this SPD.**
- 11.33 “*Initial Enrollment Period*” means the defined time frame for enrollment outlined in Sections 3.3, 3.6 and 3.7.
- 11.34 “*Late Enrollee*” means any employee or dependent who requests enrollment in the Group’s health benefit plan after the expiration of the Initial Enrollment Period and who is not eligible for a Special Enrollment Period.
- 11.35 “*Long Term Care*” Means any services furnished by a long term care or extended care facility that primarily provides supportive or maintenance care, convalescent or domiciliary care, or Custodial Care in a controlled environment including but not limited to a long term care facility, acute long term care facility, nursing home, convalescent center, residential long term care facility for mental health disorders, rest home or place of rest for the aged, youth home or similar institution.
- 11.36 “*Medical Director*” means a person trained and licensed as a medical doctor who works for the Claims Administrator to review medical issues and coverage policy related to claims or Covered Services.
- 11.37 “*Medically Necessary/Medical Necessity*” means services and/or supplies provided by a Plan Provider required to identify or treat a Member’s illness or injury and which, as determined by

the Claims Administrator's Medical Director, are

- (1) consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury;
 - (2) appropriate with regard to standards of good medical practice;
 - (3) not solely for the convenience of the Member, a Plan Physician or Plan Provider; and
 - (4) the most appropriate supply or level of service which can be safely provided to the Member.
- In the case of inpatient services, "medically necessary" further means that the Member's medical symptoms or conditions cannot be safely treated in an outpatient setting.

11.38 "*Member*" means either a Subscriber or Dependent

11.39 "*Mental Health Services*" means any one or more of the following:

- (1) the diagnosis or treatment of a mental disease, disorder, or condition as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) IV, or any other diagnostic coding system as used by the Claims Administrator.;
- (2) the diagnosis or treatment of any symptom, condition, disease or disorder by a Plan Provider (or by any person working under the direction or supervision of a Plan Provider) when the expense is:
 - (a) individual group, family or conjoint psychotherapy;
 - (b) counseling;
 - (c) psychoanalysis;
 - (d) psychological testing and assessment; or
 - (e) the administration or monitoring of psychotropic drugs;
- (3) electroconvulsive treatment;
- (4) psychotropic drugs.

Mental Health Services are not covered by your chosen physical health plan but by CorpHealth. Please see the behavioral health section of this SPD.

11.40 "*Non-diseased Tooth*" means a tooth that is whole or properly restored, and free of decay or of periodontal conditions.

11.41 "*Outpatient Care*" means all care received including services, supplies and medications in a physicians office, outpatient surgery center, x-ray or laboratory facility, the Member's home, or at a Hospital where the member receives services but is not admitted to the Hospital.

11.42 "*Outpatient Therapy Visit*" means one unit of therapeutic service (usually one hour or less) provided by licensed Plan Provider(s). An Outpatient Therapy Visit may include services provided by more than one provider and in the case of physical therapy, up to four modalities of treatment.

11.43 "*Out-of-Area Services or Out-of-Network*" means those services provided outside the Service Area or Network services outside the Service Area or Network that are arranged or authorized by the Primary Care Physician and specifically approved by the Claims Administrator are covered at the in-network benefit level as described in section 6.0. See page ii for Differences in POS and HMO options.

11.44 "*Physician*" means any physician who is duly licensed and qualified to practice within the scope of a license under the laws of the State of Arkansas or in the state in which treatment is received.

11.45 "*Plan*" means the Arkansas Public School Employee's Insurance Plan, a group health plan

designed and administered by EBD and offered by Health Advantage , and QualChoice of Arkansas. The terms of the Plan are set forth in this SPD.

- 11.46 “*Plan Administrator*” means the EBD.
- 11.47 “*Plan Hospital*” means a Hospital that, at the time of providing services to a Member, has met the participation standards of your chosen Claims Administrator, has been designated by the Claims Administrator as necessary or desirable for provision of services to Members, and has contracted with your chosen Claims Administrator to provide Hospital Services to Members.
- 11.48 “*Plan Physician*” means a Physician who, at the time of providing or authorizing services to a Member, has met the participation standards of your chosen Claims Administrator, has been designated by the Claims Administrator as necessary or desirable for provision of services to Members, and has contracted with your chosen Claims Administrator to provide Professional Services to Members.
- 11.49 “*Plan Provider*” means any Hospital, duly licensed institution, Physician, health care provider or other entity that has met the participation standards of your chosen Claims Administrator, has been designated by the Claims Administrator as necessary or desirable for provision of services to Members, and has contracted with your chosen Claims Administrator to provide health care services to Members as provided in this SPD.
- 11.50 “*Preexisting Condition*” means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the Member’s Effective Date (as defined in Section 3.0). If the Member has coverage as a result of an application submitted during the Waiting Period, the 6-month period ends on the first day of the Waiting Period. **Pre-existing condition limitations do not apply to this plan.**
- 11.51 “*Primary Care Physician*” or “*PCP*” means the Plan Physician selected by the Member who is primarily responsible for providing, arranging and coordinating all aspects of the Member’s health care. In an HMO all Members must select a Primary Care Physician from those listed by your chosen Claims Administrator to provide primary care services. Primary Care Physicians include general practitioners, family practitioners, internists, and pediatricians.
- 11.52 “*Professional Services*” means those Medically Necessary Covered Services rendered by Physicians and other health care providers in accordance with this SPD. Except for Emergency Care, all services must be performed, prescribed, directed, or authorized in advance by the Primary Care Physician.
- 11.53 “*Referral*” means an authorization to cover services issued by the Primary Care Physician.
- 11.54 “*Rider*” means additional or expanded benefits, which are made available to the Group, pursuant to applicable underwriting requirements and premium rates. Such Riders, when purchased, will be attached to and incorporated into the SPD.
- 11.55 “*Service Area*” is the State of Arkansas.
- 11.56 “*Skilled Nursing Facility*” means a facility, which provides inpatient skilled nursing care, rehabilitation services or other related health services. The term does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care,

including training in routines of daily living.

11.57 “*Special Enrollment Period*” means a thirty (30) day period during which time an employee or employee’s dependent may enroll in the Plan, after his or her initial Eligibility period or Annual Enrollment Period and not be a Late Enrollee. Special Enrollment Periods occur in two instances:

1. After The Termination Of Another Health Plan: A Special Enrollment Period occurs
 - (1) after an employee’s or dependent’s coverage under another health plan terminated as a result of loss of eligibility, or
 - (2) after the employer providing such other health plan terminated its contributions. In order for the Special Enrollment Period to apply, the employee must have stated in writing, at the time coverage under the Plan was first offered, that the employee or dependent(s) were declining coverage because of coverage under such other health plan.
2. After The Addition Of A Dependent: A Special Enrollment Period occurs for an employee, employee’s spouse or employee’s new dependent child
 - (1) after the employee marries,
 - (2) after an employee’s child is born, or
 - (3) after an employee adopts a child or has a child placed with the employee for adoption.

11.58 “*Specialty Care Physician*” means a duly licensed Plan Physician, other than a Primary Care Physician, who has been credentialed in a specialty, who practices such specialty, and who has met the participation standards of the Claims Administrator, has been designated by the Claims Administrator as necessary or desirable for provision of services to Members, and has entered into an agreement with your chosen Claims Administrator to provide Professional Services to Members.

11.59 “*Spouse*” means a member of the opposite sex who is the husband or wife of an employee as a result of a marriage that is legally recognized in the state of Arkansas.

11.60 “*Stepchild*” means a natural or adopted Child of the Spouse of the Subscriber provided:

1. Such Child lives with the Subscriber in a parent-Child relationship; and
2. The Subscriber has a legal right to claim and does claim such Child as a dependent on the Subscriber’s federal income tax return.

11.61 “*Subscriber*” means a person who meets all applicable eligibility requirements of Section 1.0, Eligibility for Coverage, and whose enrollment application and applicable premium payment have been received by EBD in accordance with the enrollment requirements of this SPD.

11.62 “*Toxic Inhalant*” means a volatile chemical designated in the Arkansas Code.

11.63 “*Urgent Care*” means care a Member receives while traveling outside the Service Area for an unexpected illness or injury that can not wait until the Member returns to the Service Area.

11.64 “*Waiting Period*” means the number of days established by the Group that must pass before a new employee who is an eligible Subscriber can commence coverage for benefits.

Attachment A

Member Complaints and Appeal Process

Complaints And Appeals Process

HMO and POS Appeals Process

(for Health Advantage, NovaSys and Qualchoice)

Authority of Employee Benefits Division

Employee Benefits Division (EBD) shall have authority and full discretion to decide all questions arising in connection with coverage under the Plan, including interpretation of Plan language and findings of fact with regard to any such questions.

DEFINITIONS:

Complaint. An expression of dissatisfaction either oral or written.

Appeal. A request to change a previous decision made by the Claims Administrator. Appeal, as used in this Attachment A, does not include appeals regarding termination of coverage. Appeals for termination of coverage are subject to the appeals procedure set out in Section 4.2.3 of the Summary Plan Description.

HOW TO SUBMIT A COMPLAINT OR APPEAL:

Complaints or Appeals may be submitted in writing to your chosen Claims Administrator.

For Health Advantage:	Health Advantage P. O. Box 8069 Little Rock, Arkansas 72203. Attention: Appeals Coordinator
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For NovaSys:	NovaSys Health P. O. Box 25224 Little Rock, Arkansas 72221 Attention: Appeals Coordinator
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For QualChoice of Arkansas:	QualChoice of Arkansas 10825 Financial Centre Parkway, Suite 400 Little Rock, Arkansas 72211 Attention: Appeals Coordinator
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Members will not suffer any sanctions or penalties resulting from submitting a Complaint or Appeal.

ORAL COMPLAINTS

A Member having a Complaint regarding any aspect of the Claims Administrator may contact a Customer Service Representative specific to the chosen Claims Administrator.

- Health Advantage 800-843-1329
- QualChoice of Arkansas 800-235-7111
- NovaSys Health 888-870-8103

The Customer Service Representative will assist in resolving the matter informally. If the Member is not satisfied with the resolution, a written Complaint may be submitted. A Member is not required to make an oral Complaint prior to submitting a written Complaint.

WRITTEN COMPLAINTS

The Claims Administrators will acknowledge receipt of a written Complaint within seven (7) working days. A thorough investigation of the Complaint will be made, and the Member will be mailed a response with resolution. If the Claims Administrator is unable to resolve the written Complaint within thirty (30) working days due to circumstances beyond its control, the member will be provided notice of the reason for the delay before the 30th working day.

HOW TO FILE AN APPEAL

An appeal must be submitted in writing to the chosen Claims Administrator at the previously documented addresses and must identify a specific action or determination of the Claims Administrator for which the Member seeks an appeal. The Claims Administrator will acknowledge receipt of the appeal within seven (7) working days.

The appeal must be made within 180 days from the date of the notice of the Claims Administrator's determination that the Member is appealing. At any stage of the appeal, the Member may designate, by signed written notice to the Claims Administrator, a representative to assist in making the appeal. Any such designation shall constitute authorization for the Claims Administrator to release any information or records regarding the appeal or the Member to the designated representative.

First Level Review

A person or persons not involved in the initial determination will review the appeal. The Claims Administrator may request additional information from the member in order to review the appeal. The Claims Administrator will respond in writing within thirty (30) days after receipt of all pertinent information. If the Claims Administrator is unable to resolve the appeal within thirty (30) working days, the Member will be notified of the delay on or before the 30th working day. The time frame for resolving the appeal shall not exceed forty-five (45) working days. If the outcome is adverse to the Member, he/she may appeal to the second level.

Second Level Review

Health Advantage

If a member is not satisfied with the determination received on the first level of appeal, a second level appeal must be made in writing within 60 days of the denial of the first level appeal. A review of the second level appeal will be conducted within 30 working days after the receipt of the Member's written appeal. The appeal will be reviewed by one of the plan's Member Response Coordinators and/or Medical Director who was not involved in the initial determination or the First Level of appeal; although such person(s) may have been communicated with during the review process.

NovaSys Health

If a member is not satisfied with the determination received on the first level of appeal, the member may appeal to the Appeals Coordinator II. The appeal must be received, in writing, within sixty (60) days of the notification of denial by the First Level Appeals Coordinator. The Appeals Coordinator II will forward the appeal to NovaSys Health's Appeals Committee, consisting of persons not involved in the initial determination or the First Level Review; although such person(s) may communicate with the committee. The Appeals Committee will review and make a determination of the Member's appeal within thirty (30) working days after receipt of the Member's Second Level Appeal.

QualChoice

If a member is not satisfied with the determination received on the first level of appeal, a second level appeal may be made in writing to QualChoice. A review of the second level appeal will be conducted within thirty (30) working days after the receipt of the Member's appeal to the second level. The appeal will be reviewed by one of the Plan's Physician Advisors who was not involved in the initial determination or the First Level of appeal, although such person(s) may be communicated with during the review process.

Final Level Review

If the outcome of the Second Level Review is adverse to the member, he/she may appeal to the Plan Administrator. Such appeal should be mailed to: Employee Benefits Division, Attention: Appeals, State of Arkansas, Department of Finance and Administration, P.O. Box 15610, Little Rock, AR 72231-5610. The decision of the Plan Administrator will be made within thirty (30) days of receipt of the written appeal and is final and binding on the Plan and the Member.

EXPEDITED APPEAL

An expedited appeal may be requested related to a claim involving urgent or ongoing care. The request may be made by telephone followed by written confirmation or in writing. If a member or someone designated by the Member and acting on behalf of the member requests an expedited appeal, the Claims Administrator's Appeals Coordinator will notify the Member or the Member's authorized representative and the member's treating health care professional of the determination of the expedited appeal in accordance with the medical needs of the case and as soon as possible, but in no case later than 72 hours after the Appeals Coordinator receives the expedited appeal.

Authorized Representative

A Member may have one representative and only one representative at a time to assist in submitting a claim or appealing an unfavorable claim determination. An authorized representative shall have the authority to represent the Member in all matters concerning the Members' claim or appeal of a claim determination. If a Member has an Authorized Representative, references to "Member", "Your" or "You" in the plan SPD refer to the Authorized Representative.

Designation of Authorized Representative

One of the following persons may act as a Member's Authorized Representative:

1. An individual designated by the Member in writing (the Claims Administrator may require this designation be documented on the Claims Administrator's approved form);
2. The treating provider, if the claim is a claim involving urgent care, or if the Member has designated the provider in writing (the Claims Administrator may require this designation be documented on the company's approved form);
3. A person holding the Member's durable power of attorney;
4. If the Member is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Member by a court of competent jurisdiction; or

5. If the Member is a minor, the Member's parent or legal guardian, unless the Company is notified that the Member's claim involves health care services where the authorization of the member's parent or legal guardian is or was not required by law and the Member shall represent himself or herself with respect to the claim.

Term of the Authorized Representative

The authority of an Authorized Representative shall continue for the period specified in the member's appointment of the Authorized Representative, or until the member is legally competent to represent himself or herself and notifies the Company in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative

1. If the Authorized Representative represents the Member because the Authorized Representative is the Member's parent or legal guardian or attorney in fact under a durable power of attorney, the Company shall send all correspondence, notices and benefit determinations in connection with the Member's claim to the Authorized Representative.
2. If the Authorized Representative represents the Member in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Company/Carrier shall send all correspondence, notices and benefit determinations in connection with the Member's claim to the Authorized Representative.
3. If the Authorized Representative represents the Member in connection with the submission of a post-service claim, the Company/Carrier will send all correspondence, notices, and benefit determinations in connection with the Member's claim to the Member, but the Company/Carrier will provide copies of such correspondence to the Authorized Representative upon request.
4. The Member understands that it will take the Company/Carrier at least thirty (30) days to notify its personnel about the termination of the Member's Authorized Representative, and it is possible that the Company/Carrier may communicate information about the Member to the Authorized Representative during this thirty (30) day period.

Attachment B

HMO Benefit
Options: Health Advantage
NovaSys Health
QualChoice of Arkansas

SCHEDULE OF BENEFITS

TABLE OF CONTENTS

PART 1.	COVERED SERVICES AND BENEFITS	<i>Page B2</i>
	A. Professional Services	<i>Page B2</i>
	B. Preventive Health Services	<i>Page B3</i>
	C. Hospital Services	<i>Page B4</i>
	D. Outpatient Diagnostic Services (Lab and X-ray)	<i>Page B4</i>
	E. Maternity and Family Planning Services	<i>Page B4</i>
	F. Rehabilitation Services	<i>Page B5</i>
	G. Emergency Care Services	<i>Page B7</i>
	H. Durable Medical Equipment and Medical Supplies	<i>Page B7</i>
	I. Prosthetics and Orthotic Devices	<i>Page B8</i>
	J. Diabetes Management Services	<i>Page B9</i>
	K. Ambulance Services	<i>Page B9</i>
	L. Skilled Nursing Facility Services	<i>Page B9</i>
	M. Home Health Services	<i>Page B9</i>
	N. Hospice Care	<i>Page B11</i>
	O. Dental Care Services	<i>Page B11</i>
	P. Reconstructive Surgery	<i>Page B11</i>
	Q. Injectable Medications	<i>Page B12</i>
	R. Allergy Services	<i>Page B12</i>
	S. Organ Transplant Services	<i>Page B12</i>
	T. Temporomandibular Joint (TMJ) Dysfunction	<i>Page B13</i>
	U. Services Requiring Prior-authorization	<i>Page B13</i>
PART 2.	A. Exclusions, Limitations and Non-Covered Services	<i>Page B14</i>
	B. Limitations as a Result of Major Disaster or Epidemic	<i>Page B19</i>

PART 1. COVERED SERVICES AND BENEFITS

The Plan provides coverage, subject to the terms and conditions, exclusions and limitations of this SPD, for medical care and services of Plan Specific Physicians and other Plan Specific Providers including medical, surgical, diagnostic, therapeutic and preventive services, which are generally and customarily provided in the Claims Administrators' Service Area, and which are determined to be Medically Necessary.

IN THE HMO PLANS, ONLY SERVICES WHICH ARE PERFORMED, PRESCRIBED, DIRECTED OR AUTHORIZED IN ADVANCE BY THE PRIMARY CARE PHYSICIAN AND THE CLAIMS ADMINISTRATORS ARE COVERED BENEFITS, UNDER THIS PLAN, EXCEPT FOR EMERGENCY CARE OR URGENT CARE. See definitions for Emergency Care and Urgent Care.

If a member has chosen coverage under an HMO plan, neither the Claims Administrators nor Plan Physicians shall have any liability whatsoever for any services sought or received by the Member from a non-plan physician, provider or facility, except as described in Section 6.0. Out of Service Area and Section G., Emergency Care Services, of this Schedule of Benefits, unless prior Referral authorization arrangements have been made by both the Primary Care Physician and the Claims Administrators. Coverage for all services is limited to Allowable Charges unless otherwise provided by the specific contract of a Plan Physician or Plan Provider. If a member has chosen coverage under a POS Plan, the above rules should be followed in order to maximize benefits and lessen out of pocket expenses.

MEMBERS ARE LIABLE FOR COPAYMENTS AND COINSURANCE TO PLAN PROVIDERS FOR SPECIFIED SERVICES AS SET FORTH BELOW AND AMOUNTS IN EXCESS OF THE CLAIMS ADMINISTRATOR'S ALLOWABLE CHARGES BILLED BY NON-PLAN PROVIDERS.

The Copayment and Coinsurance amounts, Annual Coinsurance Limit, and benefit limits are specified in the, Benefit Summary. Copayment amounts are not applied to the Annual Coinsurance Limit. Annual maximum benefit limits are based on the Group Contract Year.

A. Professional Services

In an HMO, subject to all terms, conditions, exclusions and limitations of this Plan, coverage is provided for the following professional services when authorized or arranged by the Primary Care Physician (PCP) and provided by Plan Providers. Each member must select a PCP who shall provide, arrange and manage the health care needs of the Member. Members may select or change their PCP by calling the chosen Claims Administrator Customer Service or submitting a change form to The Claims Administrator. Failure to select a PCP may result in a PCP being assigned by The Claims Administrator or denial of services. If you have chosen coverage under a POS, you are required to select a primary care physician, however, if you bypass your PCP, coverage will be limited to your open choice benefit. You must satisfy your POS open choice deductible prior to any payment being made to your provider and you will be subject to an increased out of pocket expense.

1. *Primary Care Physician Office Visits.* Coverage is provided for the diagnosis and treatment of illness or injury when provided in the medical office of the Primary Care Physician. Member is responsible for the Copayment/Coinsurance specified in the Benefit Summary, for each visit.

2. *Plan Specialist Physician Office Visits.* Coverage is provided for the diagnosis and treatment of illness or injury when provided in the medical office of a Plan Specialist Physician. For HMO plan members, all Specialty services require a Referral from the Primary Care Physician prior to seeking care except for gynecological and obstetrical visits. Plan Specialist Physician office visits are subject to the Copayment specified in the Benefit Summary. POS plan members may access care out-side of the provider network without a referral, however, this will increase your financial liability. See section ii, Plan Options, for specific differences in HMO and POS plans. *Second Opinion.* Claims Administrators may request a second opinion from a Plan Physician before approving coverage for an out of network Referral. Upon a Member's request, Claims Administrators may, at its discretion, authorize a second surgical opinion for a condition for which diagnosis or treatment has already been recommended.
3. *Plan Physician Hospital Visits.* Coverage is provided for services of Plan Physicians for diagnosis, treatment and consultation while the Member is confined as an inpatient in the hospital for Medically Necessary Covered Services subject to the Inpatient Copayment/Coinsurance specified in the Benefit Summary.
4. *Plan Physician Home Visits.* Coverage is provided for Medically Necessary home visits by Plan Physicians when, in the judgment of the Primary Care Physician, the nature of the illness or injury so indicates. Home visits are subject to the limitations and Copayment/Coinsurance provided herein for specific Plan Physician office visits.
5. *Other Plan Provider Home Visits.* Care in the home by Health Care Professionals, who are Plan Providers, including but not limited to registered nurses, licensed practical nurses, physical therapists, inhalation therapists, speech and hearing therapists, and other licensed providers, is a covered benefit when prescribed, authorized or ordered by the Primary Care Physician, subject to the limitations and Copayment/Coinsurance provided herein for specific services, provided the services are not considered custodial in nature.
6. *Chiropractic Services.* Coverage is provided for chiropractic outpatient services when authorized by the Primary Care Physician in the HMO plan. The Member is responsible for the Copayment/Coinsurance specified in the Benefit Summary. Members with coverage under the POS plan may access Chiropractic Services utilizing the open choice (out of network) portion of the plan but will be subject to a reduction of benefits outlined in the Benefit Summary.

B. Preventive Health Services

Subject to all terms, conditions, exclusions and limitations of this Plan, coverage is provided for preventive health services according to the Claims Administrator's Preventive Health Guidelines when authorized by the Primary Care Physician. The Member is responsible for the Copayment for specific services specified in the Benefit Summary. The following are examples of preventive health services:

1. Well baby care for Members up to age two (2) years and well child care over the age of two (2) years when performed or authorized by the Primary Care Physician.
2. Immunizations.
3. Pap smears for cervical cancer screening.
4. Mammograms for breast cancer screening.
5. Osteoporosis screening for women.
6. ***Eye and hearing exams for the purpose of diagnosis or treatment of disease or condition or due to injury to the eyes or ears is covered.***
7. Prostate-specific antigen test for detection of cancer is covered for males.
8. Periodic health assessments for adults, based on age, sex and medical history when performed or authorized by the Primary Care Physician.

C. Hospital Services

Subject to all terms, conditions, exclusions and limitations of this Plan, coverage is provided for the following Hospital Services. All Hospital Services must be authorized or arranged by the Primary Care Physician and provided by a Plan Hospital, except as provided in Section 6.0 Out of Service Area Services and Section G., Emergency Care Services in the HMO. The Member is responsible for the inpatient Copayment and Coinsurance specified in the Benefit Summary.

1. Inpatient Services. Coverage is provided for the following inpatient services when provided, arranged or authorized by the Primary Care Physician in the HMO:
 - a. Semi-private room, including special care units, general nursing services, meals and special diets; private rooms when Medically Necessary and in Hospitals with only private rooms.
 - b. Laboratory, x-ray and other diagnostic services.
 - c. Medications, biologicals and their administration.
 - d. Physician services.
 - e. Surgical services, use of operating and delivery rooms and related facilities.
 - f. Anesthesia and oxygen services.
 - g. Radiation therapy, inhalation therapy, hemodialysis, and chemotherapy (see definition, exclusion and limitations for high-dose chemotherapy and Allogeneic bone marrow transplantation).
 - h. Blood and blood plasma and their administration (see definition, exclusion and limitations for Allogeneic bone marrow transplantation).
 - i. Equipment and medical supplies while receiving inpatient services except those equipment items that are specifically excluded herein.
2. Outpatient Services. Coverage is provided for services of a hospital outpatient department or outpatient surgery center when Medically Necessary and authorized by the Primary Care Physician in the HMO subject to the Copayment/Coinsurance specified in Attachment C, Benefit Summary.
 - a. Dialysis, Radiation therapy, Chemotherapy (see definition, exclusion and limitations for high-dose chemotherapy and Allogeneic bone marrow transplantation).
 - b. Physical, occupational, and speech therapy .
 - c. Outpatient surgery, anesthesia and use of facility.

D. Outpatient Diagnostic Services (Laboratory and X-ray)

Subject to all terms, conditions, exclusions and limitations of this Plan coverage is provided for laboratory and radiographic procedures, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests and therapeutic radiology services when ordered, authorized or arranged by a Plan Physician in the HMO.

E. Maternity and Family Planning Services

Subject to all terms, conditions, exclusions and limitations of this Plan, coverage is provided for Maternity and Family Services when performed, authorized or arranged by a Plan Physician subject to the Copayment/Coinsurance amounts specified in Attachment C, Benefit Summary for HMO member. POS members may access care outside of the provider network without a PCP referral, however, this will increase your financial liability. See section ii, Plan Options, for specific differences in POS and HMO plans. Coverage for all treatment of infertility is non-covered.

1. Maternity Care. Coverage is provided for maternity care including pre and postnatal care; use

of hospital delivery rooms and related facilities; use of newborn nursery and related facilities; special procedures as may be Medically Necessary. See specific exclusion for Services outside Service Area. No Member office visit Copayment is required for pre and postnatal visits after the initial office visit. Group health plans and health insurance issuers generally, may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

2. Newborn Care in a Plan Hospital. Newborn Children of the Subscriber or Spouse will be covered from date of birth provided the Subscriber enrolls the newborn within thirty (30) days of birth if the Subscriber has coverage for Employee only or Employee and Spouse, or ninety (90) days after the date of birth if the Subscriber has Dependent Coverage.
3. Family Planning Services. Coverage is provided for the following family planning services when authorized and provided by Plan Physicians:
 - a. Counseling and planning services for infertility when provided by Plan Physicians.
 - b. Infertility Testing. Medically Necessary testing for infertility, as determined by a Plan Physician. Diagnostic procedures are limited to semen analysis, endometrial biopsy, hystero-salpingography and diagnostic laparoscopy. See specific exclusion and limitations for Family planning and infertility services.
 - c. Voluntary sterilizations (vasectomies and tubal ligations are covered.)
 - d. Pregnancy terminations are covered only when done to save the mothers life and when performed in a Plan Hospital.

NOTE: Treatment of infertility is not a covered benefit.

F. Rehabilitation Services

Subject to all terms, conditions, exclusions and limitations of this Plan, coverage is provided for inpatient and outpatient rehabilitation services when authorized, arranged or rendered by Plan Providers in the HMO. The Member is responsible for the Copayment/ Coinsurance amount specified in the Benefit Summary. In the POS plan, accessing care without the authorization of a Primary Care Provider will lead to the payment of benefits under the out-of-network option.

1. Inpatient Rehabilitation: Coverage is provided for inpatient rehabilitation services, including professional services, when authorized or arranged by a Plan Physician and rendered in a Plan Hospital in the HMO. Inpatient stays for rehabilitation are limited to sixty (60) days per Member per Contract Year.
2. Outpatient Rehabilitation Therapy: Coverage is provided for outpatient rehabilitation services when authorized or arranged by a Plan Physician in the HMO. Coverage for outpatient visits for physical, occupational, and speech therapy, chiropractic services and cardiac rehabilitation are limited to a maximum of 60 aggregate visits per Member per Contract Year. See definition for Outpatient Therapy Visit.

G. Emergency Care Services

Subject to all terms, conditions, exclusions and limitations of this Plan, coverage is provided for Emergency Care Services. When Emergency Services are needed the Member should seek care at the nearest facility. Emergency Care is subject to medical review.

1. **Emergency Care.** Coverage is provided for Emergency Care as defined in this SPD. The Member is responsible for the Copayment specified in Attachment C, Benefit Summary for each Emergency Care visit. The Copayment is waived if the Member is admitted as an inpatient directly from the emergency room to the hospital. Hospital admission Copayments are applicable, as provided in the Benefit Summary.
2. **Contact Primary Care Physician.** If prior authorization for coverage was not received, the Member is required to contact the Primary Care Physician within twenty-four (24) hours of receiving Emergency Care services, or as soon as possible without being medically harmful or injurious to the Member. Coverage for Emergency Care will be subject to medical review, and if the level of care received indicates that the need for Emergency Care as defined in this SPD did not exist, payment may be denied and the charges will then become the financial responsibility of the Member.
3. **After-Hours Clinic or Urgent Care Center.** Services provided in an after-hours or urgent care center are subject to the Emergency Care Copayment for each visit.
4. **Observation Services.** Observation services are covered when ordered by a Plan Physician. Observation Services ordered in conjunction with an emergency room visit are subject to the Emergency Care Copayment. When Observation Services are ordered from an outpatient clinic, the Member is responsible for the Observation Copayment specified in the Benefit Summary. If the Member is admitted as an inpatient, the inpatient Copayment and Coinsurance is applicable.
5. **Follow-up Care.** For optimal benefit in an HMO plan, continuing or follow-up treatment for accidental injury or Emergency Care is limited to care that is Medically Necessary before the Member can be safely transferred, without medically harmful or injurious consequences, to a Plan Hospital in the Service Area. Services are subject to all applicable Copayments.
6. **Coverage limitations.** Coverage for Emergency Care services will be subject to medical review. Based upon the signs and symptoms presented at the time of treatment as documented by attending health care personnel, coverage for any emergency visit that is reviewed by Claims Administrators and fails to meet the standards for Emergency Care as set out in this SPD may be denied and it will become the Member's liability.

H. Durable Medical Equipment and Medical Supplies

Subject to all terms, conditions, exclusions and limitations of this Plan, coverage is provided for Durable Medical Equipment (DME) and medical supplies when prescribed or authorized by a Plan Provider in the HMO and according to the guidelines specified below subject to the Copayment /Coinsurance specified in the Benefit Summary and subject to an annual maximum of \$10,000 per Member per Contract Year. See also Section J., Diabetes Management Services and Section M., Home Health Services. Coverage under the POS plan is available out-of-network subject to the Copayment/Coinsurance for that option in all the following situations.

1. **Durable Medical Equipment** is that equipment which, in absence of illness or injury, is of no medical or other value to the Member. With the exception of the items listed in subsection 3. below, only Durable Medical Equipment and medical supplies covered by Medicare will be covered under this SPD. Examples of Durable Medical Equipment include, but are not limited to oxygen equipment, wheelchairs, crutches, etc. and provided as a result of Medical

Necessity, not for the convenience of the Member or any other person.

2. Certain DME items including but not limited to insulin infusion pumps, external ambulatory infusion pumps, transcutaneous electrical nerve stimulators (TENS) units, bone stimulators, and equipment used in treatment of sleep apnea for adults, must meet medical coverage criteria to be a covered benefit.
3. Coverage for Non-Medicare Durable Medical Equipment and supplies is provided when authorized by a Plan Physician and obtained through a Plan Provider (in the HMO) for surgical stockings and safety equipment such as tub rails or bench, raised toilet seat, and bed cradle. Coverage under the POS option is subject to applicable Copayment/Coinsurance.
4. Medical supplies are covered when prescribed or authorized by a Plan Provider in the HMO. Coverage for medical supplies is limited to a thirty-one (31) day supply per purchase.
5. Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Eyeglasses and contact lenses following cataract surgery are limited to the initial acquisition only and must be purchased within six (6) months of date of surgery. Maintenance and repairs resulting from misuse or abuse are the responsibility of the Member. DME repairs is approved under certain circumstances when prior-approved by the Claims Administrator.
6. All Durable Medical Equipment and medical supplies must be obtained through a Plan Provider in the HMO. All Durable Medical Equipment remains the property of the Claims Administrator or a Plan Provider. When it is more cost effective, the Claims Administrator in its discretion will purchase rather than lease equipment. The amount paid for leasing a DME equipment item should not exceed the Allowable Charge for equipment purchase. Claims Administrators retains the right to recover any equipment purchased by Claims Administrators for the use of the Member upon cancellation or termination of coverage for the Member.

I. Prosthetics and Orthotic Devices

Subject to all terms, conditions, exclusions and limitations of this Plan, coverage is provided for prosthetic devices that aid in bodily functioning or replace a limb or other body part after accidental or surgical loss, and orthotic devices used for correction or prevention or skeletal deformities when authorized or prescribed by a Plan Physician in the HMO subject to the Copayment /Coinsurance specified in the Benefit Summary.

1. Coverage is provided for orthopedic appliances used to support, align, or hold bodily parts in a correct position, including rigid back, leg or neck braces, back corsets, and physician-prescribed, directed or applied devices which are custom designed for the purpose of assisting joint function.
2. When prescribed by a Plan Provider in the HMO, coverage is provided for podiatric appliances for complications associated with diabetes and for orthotic devices for children following reconstructive surgery for a congenital anomaly. See specific exclusion for prosthetics and orthotic devices. Accessing coverage in the POS without Primary Care Provider's authorization will result in a reduction of benefits.
3. In order to be covered, appliances must be a prosthetic or orthotic device as defined by the Medicare DME Manual. Repair or replacement of devices due to normal growth or wear is a covered benefit. Maintenance and repairs resulting from misuse or abuse are the responsibility of the Member.

NOTE: Prosthetics and orthotic devices are subject to an annual maximum of \$15,000.

J. Diabetes Management Services

Subject to all terms, conditions, exclusions and limitations of this Plan, coverage is provided for Diabetes equipment and supplies and Diabetes Self-Management Training when obtained through a Plan Provider and prescribed or authorized by a Primary Care Physician in the HMO subject to the Copayment/Coinsurance specified in the Benefit Summary. Access to this benefit under the POS plan without a Primary Care Physician's authorization will result in a reduction of benefits.

1. Diabetes Equipment and Supplies. Diabetic supplies not covered by a Prescription Medication Program, such as insulin pumps and insulin pump supplies, are limited to a 31-day supply per purchase. Podiatric appliances for prevention of complications associated with diabetes are covered.
2. Diabetes Self-Management Training. Services for Diabetes Self-Management Training require a Referral from the Primary Care Physician and must be provided by an approved Plan Provider in the HMO plan. Access to this benefit under the POS plan without a Primary Care Physician's authorization will result in a reduction of benefits.

NOTE: Diabetic equipment and supplies including insulin pump and insulin pump supplies are not subject to the DME and medical supply annual maximum of \$10,000.

K. Ambulance Services

Subject to all terms, conditions, exclusions and limitations of the Plan, coverage is provided for ambulance services in the event of Emergency Care, as defined in this SPD. Ambulance service means the transportation of a Member by surface or air in a regularly equipped ambulance licensed by an appropriate agency. Ambulance services are limited to an annual maximum of \$1000 per Member per Contract Year. Life saving medications are not subject to the maximum annual benefit.

NOTE: Non-emergency ambulance use is not covered.

L. Skilled Nursing Facility Services

Subject to all terms, conditions, exclusions and limitations of the Plan, coverage is provided for Skilled Nursing Facilities when Medically Necessary and authorized in advance by the Primary Care Physician in an HMO as follows:

1. Coverage is provided for a maximum of sixty (60) days per Member per Contract Year, if the Skilled Nursing Facility services are of a temporary nature and lead to rehabilitation and increased ability to function.
2. Members covered under the HMO Plan, remaining in a Skilled Nursing Facility after discharge by the Primary Care Physician, or after the maximum benefit period or period authorized is reached, shall be liable for all subsequent costs incurred. Members covered under the POS Plan, remaining in a Skilled Nursing Facility maximum benefit period or period authorized is reached, shall be liable for all subsequent cost incurred.

NOTE: Custodial care is not a covered benefit.

M. Home Health Services

Subject to all terms, conditions, exclusions and limitations of the Plan, coverage is provided for Home Health Services when the Member's medical condition supports the need for in-home service and such care is prescribed, authorized or ordered by the Primary Care Physician in an HMO. All

services provided in the home by Plan Providers, including but not limited to registered nurses or licensed practical nurses, physical therapists, inhalation therapists, speech or hearing therapists, and other licensed health care providers is covered subject to the limitations and the Copayment/Coinsurance provided for specific services contained herein in an HMO. Coverage for this benefit in the POS plan is available and will result in a reduction of benefits if accessed without a Primary Care Physician's approval or is out-of-network. Home Health nursing visits are limited to 120 visits per Member per Contract Year. Please note:

1. Medical Supplies used for Home Health Services are not subject to the DME and medical supply annual maximum of \$10,000.
2. DME equipment items and medical supplies for use with the DME equipment for Home Health Services are subject to the DME and medical supply annual maximum of \$10,000.

N. Hospice Care

Subject to all terms, conditions, exclusions and limitations of the Plan, coverage is provided for Hospice services when prescribed or authorized by the Primary Care Physician in the HMO Plan, and pre-approved by the Claims Administrators. See Benefit Summary Section for plan specifics Copayment/Coinsurance.

NOTE: Custodial care is not a covered benefit.

O. Dental Care Services

Subject to all terms, conditions, exclusions and limitations of the Plan, coverage is provided for the following dental services in an inpatient or outpatient setting when authorized by the Primary Care Physician. See also Section T. Temporomandibular Joint Dysfunction.

1. Services for treatment and x-rays necessary to correct damage to non-diseased teeth or surrounding tissue caused by an accident or Sjögren's syndrome occurring on or after effective date of coverage are covered. Member must seek treatment within seventy-two (72) hours of injury for services to be covered.
2. Treatment or correction of a non-dental physiological condition caused by Sjögren's syndrome or injury that has resulted in severe functional impairment.
3. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
4. Removal of impacted wisdom teeth.
5. Pre-treatment dental services in connection with the treatment of cancer of the head or neck.

NOTE: General dental services are not covered. Injury to teeth while eating is not considered an accidental injury and therefore will not be covered.

P. Reconstructive Surgery

Subject to all terms, conditions, exclusions and limitations of the Plan, coverage is provided for Reconstructive Surgery when Medically Necessary and authorized by the Primary Care Physician in the HMO Plan. The following services are covered subject to applicable Copayments/Coinsurance specified in the Benefit Summary specific to the point of access for HMO or POS.

1. Treatment provided for the correction of defects incurred in an accidental injury sustained by the Member while covered under this Plan or follow-up care for accidental injury which could not have been provided at an earlier date.

2. Surgery performed on a child twelve (12) years and under for the correction of a cleft palate or hair lip, removal of a port-wine stain on the face, or correction of a congenital abnormality.
3. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery while the Member was covered under this Plan.
4. In connection with a mastectomy resulting from cancer surgery, services for (a) reconstruction of the breast on which the cancer-related surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphedemas. Three (3) mastectomy bras per year covered.
5. Reduction mammoplasty with prior approval for coverage by the Claims Administrator when deemed Medically Necessary.

Q. Injectable Medications

Subject to all terms, conditions, exclusions and limitations of the Plan, coverage is provided for injectable medications while confined as an inpatient, or when provided and administered by Plan Physicians in a clinic setting. Many injectable medications require prior authorization for coverage by the Claims Administrator. Members may contact Customer Service to verify if an injectable medication requires prior authorization for coverage. The Member is responsible for the appropriate office visit Copayment. Injectable medications not given in conjunction with hospital confinement or administered by a physician are available through your prescription drug benefit at a local pharmacy. Intravenous medication provided in conjunction with Home Health Services, are covered by your Medical Health Plan.

R. Allergy Services

Subject to all terms, conditions, exclusions and limitations of the Plan, coverage is provided for allergy services when deemed Medically Necessary and authorized by the Primary Care Physician in the HMO Plan. Services include allergy testing and evaluation, therapy, injections and serum. The Member is responsible for the appropriate office visit Copayment.

S. Organ Transplant Services

Subject to all terms, conditions, exclusions and limitations of the Plan, coverage is provided for transplant services subject to the benefit maximums and requirements specified in the following:

1. Transplant procedures are covered for human to human organ or tissue transplants if they are Medically Necessary and not Experimental or Investigational. Covered transplant services for the recipient include the expense categories of organ procurement, hospital expense, physician expense, nursing care, equipment rental, rehabilitation, and outpatient expenses in connection with covered transplant procedures. Covered transplant services for the donor include hospital expense, physician expense, nursing care and outpatient expenses related to organ donation when the recipient is a Member of Claims Administrators' plan; however, expenses for testing of a donor who is found to be incompatible are not covered. See specific exclusion for Donor services. A life-time allowance of up to \$10,000.00 for transportation, lodging, and meals is provided in connection with a covered transplant. Transplant coverage is subject to prior authorization by the Claims Administrator.

2. Coverage is limited to no more than two (2) transplants per Member per lifetime. Coverage is for the transplant operation, initial hospitalization, and related aftercare. Retransplantation is covered, subject to the two-transplant limit.

3. In order to be eligible for coverage, the Member must notify Claims Administrator prior to receiving any transplant services, including transplant evaluation. The Claims Administrator must coordinate all transplant services, including transplant evaluation. If you have specific questions about your transplant benefits, contact your chosen Claims Administrator.

**NOTE: Certain transplant services are not covered at all under this Plan.
See specific exclusion for Transplant Procedures.**

T. Temporomandibular Joint (TMJ) Dysfunction

Subject to all terms, conditions, exclusions and limitations of the Plan, coverage is provided for Medically Necessary diagnostic procedures, evaluations, surgical treatment, intra-oral reversible prosthetic devices and pharmacological treatment of the temporomandibular joint subject to the Copayment/Coinsurance specified in the Benefit Summary, and a \$500 maximum per Member per lifetime. See specific exclusions for Dental care and TMJ.

U. Services Requiring Prior-authorization

Prior-authorization is applicable to both the HMO and POS options. It is applicable to the POS regardless of the level of benefit chosen. Contact the claims administrator for prior-authorization based on the health plan administrator's lists below;

For Health Advantage:

- Breast Reductions not related to cancer
- Enteral Formula
- Swing Bed Care
- Transplant Services (Including the initial evaluation)
- Out of Network Services (This would include services for dental accidents)

For QualChoice:

- Any Admission to an Inpatient Facility
- Ultrasounds – During Pregnancy, QualChoice will allow the initial ultrasound. Additional ultrasounds must receive prior-authorization.
- Home Health Care, Home Infusion Services or Hospice (Inpatient or Outpatient) whether provided by a Home Health Agency, Hospital, Physician or other provider.
- Transplant Services (Including the initial evaluation)
- PET Scan when performed on an outpatient basis, whether in an office, a clinic, a hospital outpatient department or any other outpatient setting.
- Gamma Knife Procedures
- DME Repairs
- Out-of-network referrals

For NovaSys Health

- All Inpatient Admissions
- Transplant Services
- Adenoidectomy
- Arthroscopy of the knee
- Carpal Tunnel Release
- Inguinal Herniorrhaphy
- Laproscopy
- Mammoplasty
- Nasal Surgery
- Stripping and Ligation of Varicose Veins
- Tonsillectomy

Out-of-Network Referrals require prior-authorization by the Claims Administrators.

A referral by your Network Primary Care Physician to an out-of-network provider or an order or prescription for services from an out-of-network provider by a network provider without pre-authorization from the Claims Administrator DOES NOT constitute approval for benefits.

PART 2. HMO/POS EXCLUSIONS, LIMITATIONS AND NON-COVERED SERVICES

A. Exclusions and limitations. This PART 2 contains general exclusions and limitations of the plan. Other parts of this SPD and Schedule of Benefits dealing with coverage of specific services, treatments, medications and supplies contain additional exclusions and limitations. This Plan does not cover the following services, treatments, medications, and supplies:

1. Abortion. Purely elective or voluntary abortions are not covered. Pregnancy terminations are covered, but only to save the mother's life, when pre-approved by the claims administrator and performed in a network hospital.
2. Acupuncture. Services related to acupuncture are not covered.
3. Allogeneic bone marrow transplantation. Allogeneic bone marrow transplantation and all related procedures (including High Dose Chemotherapy) designed to replace bone marrow or peripheral blood cells are not covered. The only instances in which services, supplies or drugs associated with allogeneic transplantation and related procedures will be covered are in the treatment of diseases of the bone marrow listed in a. through c. below when the specified donor match is used:
 - a. The following diseases when the acceptable donor matches patient at all six HLA antigens and the patient and donor cells are nonreactive in mixed leukocyte culture:
 - Aplastic anemia;
 - Wiskott-Aldrich syndrome;
 - Infantile malignant osteopetrosis (Albers-Schonberg syndrome or marble bone disease);
 - Homozygous beta-thalassemia (thalassemia major); or
 - Myelodysplastic Syndromes (including primary [e.g. idiopathic] and acquired [e.g. secondary to drug or toxin exposure] forms using 6 of 6 antigen matched, mixed lymphocyte culture negative, family member donor).
 - b. Acceptable donor matches the patient at three or more of six HLA antigens; patient and donor cells are nonreactive in mixed leukocyte culture, and the patient has severe combined immunodeficiency syndrome (e.g. adenosine deaminase deficiency and idiopathic deficiencies).
 - c. For the following malignancies in which the acceptable donor is related or unrelated to the patient with matches at all six HLA loci and patient and donor cells are nonreactive in mixed leukocyte culture:
 - Non-Hodgkin's lymphoma, intermediate or high grade stage III or stage IV;
 - Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB;
 - Neuroblastoma, stage III or stage IV; or
 - Chronic myelogenous blast leukemia in blast crisis or chronic phase.
 - d. The following diseases for patients in absence of HLA identical donor, if acceptable donor is related (haploidentical) to the patient with one or more antigen mismatches and the patient and donor cells are nonreactive in mixed leukocyte culture:
 - (1) Acute lymphocytic or nonlymphocytic (acute myelocytic) leukemic patients who are in first or subsequent remission, but at high risk for relapse. Factors associated with high risk for relapse are:
 - age greater than fifteen (15) years;
 - leukocyte count greater than 10×10^9 per liter;
 - extramedullary disease (especially central nervous system disease);
 - leukemic blast with chromosomal translocations; and
 - failure to achieve a complete remission within six weeks of the start of induction therapy.
 - (2) Chronic myelogenous leukemia in chronic phase.
 - e. Multiple Myeloma in patients under the age of fifty-five (55) years when performed with an HLA-matched donor.
4. Appointments/medical records. Charges resulting from the failure to keep a scheduled visit with a Plan or Non-Plan Physician or other Plan or Non-Plan Provider; or for completion of any insurance forms; or for acquisition of medical records are not covered.

5. Bereavement services. Medical Social services and outpatient family counseling and/or therapy for bereavement, except as provided as Hospice Care, are not covered.
6. Biofeedback. Hypnotherapy, biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered.
7. Chelation therapy. Services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning are not covered.
8. Cochlear implants. Coverage for cochlear implants is limited to one cochlear implant device, the surgical procedure and speech processor subject to the Claims Administrators' approval and a maximum of \$35,000 limit per Member per lifetime. Reimplantation of the same device is not covered.
9. Comfort items. Private hospital rooms are covered only when Medically Necessary and authorized by the Plan Physician in an HMO. Personal or comfort items such as television, radio, telephone, guest meals, personal computer with or without assistive talking devices, automobile/van conversion or addition of patient lifts, hand controls, or wheel chair ramps, and home modifications such as overhead patient lifts and wheelchair ramps are not covered.
10. Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under this SPD are not covered.
11. Contraceptive devices. Covered charges for contraceptive services are limited to insertion and removal of contraceptive devices. Contraceptive devices including but not limited to IUD, subcutaneous contraceptive implant, diaphragm, foams and jellies are not covered.
12. Cosmetic services. All services or procedures related to or complications resulting from Cosmetic Services are not covered.
13. Court ordered or third party recommended treatment. Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, and services ordered by the court or arranged by law enforcement officials, unless such order is being sought by a Primary Care Physician in an HMO or unless otherwise covered by this SPD are not covered.
14. Custodial care. Services or supplies for Custodial, convalescent, domiciliary, supportive or maintenance care, and non-medical services to assist a Member with activities of daily living are not covered.
15. Dental care. Dental Implants are not covered except when required following accidental injury or as a result of SjÖgren's syndrome. Dental abutments, dental restorations, and services or supplies for dental care, except as provided in Part 1., Section O., of this Schedule of Benefits are not covered. Orthognathic surgery and Orthodontics and braces regardless of Member's age are not covered.
16. Domestic Partners. Domestic partners of the same sex or opposite sex are not covered.
17. Donor services. Services or supplies incident to organ and tissue transplant, or other procedures when the Member acts as the donor are not covered except for Autologous services. When the Member is the potential transplant recipient, expenses for testing of a donor who is found to be incompatible are not covered.
18. Eating Disorders. Anorexia, bulimia, and services related to eating disorders are not covered except for medical stabilization or related conditions such as bradycardia or fluid and electrolyte imbalance. See Behavioral Health and Substance Abuse Section.
19. Electrotherapy stimulators. All treatment using electrotherapy stimulators, services and supplies used in connection with treatment, and complications resulting from the treatment are not covered.
20. Enteral Feedings. Enteral tube feedings are not covered except when it is the sole source of nutrition, approved by a Plan Physician in an HMO, and prior authorized by Claims Administrators.
21. Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge is not covered.

22. Exercise programs. Exercise programs for treatment of any condition are not covered.
23. Experimental/Investigational. Any treatment, procedure, facility, equipment, drug, device or supply deemed by Claims Administrators or EBD to be Experimental or Investigational as defined in this SPD is not covered. Diagnostic procedures, services and supplies provided in connection with Experimental or Investigational studies or treatment are not covered.
24. Eye care. Refractive keratoplasty, epikeratophakia procedures, Low Vision Enhancement System (LVES), and eyeglasses and contact lenses except the initial acquisition following cataract surgery are not covered.
25. Family planning and infertility services. Any services or supplies provided for, in preparation for, or in conjunction with the following are not covered except as provided in Section E (B-5):
 - Elective or voluntary abortions; and complications for these procedures.
 - Sterilization reversal (male or female).
 - Sexual dysfunction including sex therapy.
 - Surrogate mother services or in vitro fertilization.
 - Treatment of infertility.
26. Foot care. Services or supplies for treatment of flat feet or fallen arches, routine foot care such as hygiene care, removal of corns, warts or calluses, and toenail trimming, except when required for prevention of complications associated with diabetes are not covered.
27. Genetic testing. Services related to genetic testing are limited to those approved by Claims Administrators. Examples of genetic testing that are covered include but are not limited to testing for Down's syndrome, phenylketonuria/galactosemia, (PKU) medullary thyroid carcinoma, hypothyroidism and sickle-cell anemia.
28. Government coverage. Coverage for which the Member is eligible through entitlement programs of the federal, state, or local government, including but not limited to any insurance carrier, Veterans Administration, Medicare, or Medicaid are not covered.
29. Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician are not covered under medical benefits. See the section of this SPD covering prescription drug benefits.
30. Hearing or talking aids. Hearing aids or assistive talking devices including special computers are not covered.
31. High dose chemotherapy. High Dose Chemotherapy and all related procedures, including but not limited to autologous bone marrow transplantation, allogeneic bone marrow transplantation, stem cell rescue or similar treatment or procedures designed to replace or rejuvenate bone marrow or peripheral blood cells are not covered. Other than for allogeneic bone marrow transplantation, (Exclusion 3), the only instances in which drugs, services or supplies associated with High Dose Chemotherapy and related procedures will be covered are in the following limited circumstances:
 - For a diagnosis of Non-Hodgkin's lymphoma, when classified as intermediate or high grade stage III, or stage IV; or
 - For a diagnosis of Hodgkin's disease classified as stage IIIA, IIIB, IVA or IVB; or
 - For a diagnosis of neuroblastoma, when classified as stage III or stage IV; or
 - For a diagnosis of acute lymphocytic or non-lymphocytic leukemia following a first or any subsequent relapse; or
 - tumors that are refractory to standard dose Chemotherapy with a U. S. Food and Drug Administration platinum compound. Refractory cases include (1) patients with advanced disease who fail to achieve a complete response to second-line therapy, and (2) patients with moderate or minimal extent disease who fail to achieve a complete response to third-line therapy. Disease extent (e.g., minimal, moderate, advanced) refers to germ cell tumor stage according to the Indiana University/Einhorn Classification; or
 - For a diagnosis of breast cancer under the following conditions: (1) 10 or more positive nodes in the adjuvant setting; or (2) inflammatory breast cancer at the time of the diagnosis of the

cancer; or (3) stage II or III metastatic breast cancer that has relapsed after first line therapy; or (4) stage II or III metastatic breast cancer that is known to be chemotherapy sensitive (partial or complete response to prior chemotherapy) and are at high risk of relapse. Such patients must have adequate marrow function with no evidence of marrow involvement of the disease.

- For a diagnosis of multiple myeloma in patients who meet the coverage criteria established by the Claims Administrator based on nationally excepted standards. (These criteria are available upon request by the physician from the Claims Administrator's Medical Director.)
- For children up to eighteen (18) years of age with pineoblastoma who have shown response to standard chemotherapy and whose disease is localized in the brain.
- For children or young adults up to thirty-two (32) years of age with metastatic Ewing's sarcoma.

NOTE: In each of the cases outlined above, the following conditions must be satisfied in order for High Dose Chemotherapy to be a covered benefit:

- (1) the patient's disease characteristics and treatment history suggest that the probability of achieving a durable, complete remission are greater with High Dose Chemotherapy compared to standard treatment or conventional dose Chemotherapy; and
 - (2) the patient does not have a concurrent condition which would seriously jeopardize the achievement of a durable, complete remission with High Dose Chemotherapy.
32. High frequency chest wall oscillators and any type of portable device including inflatable vests used to create an airflow within the lungs have limited coverage and are only approved after medical review.
 33. Infertility treatment. Services for the treatment of infertility are not covered.
 34. Long term care. Services or supplies furnished by an institution, which is primarily a place of rest or a place for the aged, residential long term care for mental health disorders, youth homes, or any similar institution are not covered.
 35. Midwives. Services provided by midwives are not covered unless working under the direction of a Plan Physician.
 36. Naturopath/Homeopath services. Naturopathic or Homeopathic remedies for treatment of any condition are not covered.
 37. Non-covered services. Services not specifically included as a benefit herein, complications related to non-covered services, services provided after exceeding the benefit maximum for specified services, and services for which the Member is not responsible for payment are not covered.
 38. Non-Medicare covered Durable Medical Equipment. Medical equipment and supplies that are not covered by Medicare are excluded except as specified in Part I, Section I. Examples of excluded items include the purchase or rental of air conditioners, air purifiers, waterbeds, motorized transportation equipment except with prior approval, automobile/van conversion or addition of patient lifts, hand controls, or wheel chair ramps, home modifications such as overhead patient lifts and wheelchair ramps, exercise equipment, or similar items. Replacement or repair of Durable Medical Equipment and prosthetic devices is not covered except when Medically Necessary. Disposable items are not covered.
 39. Non-plan provider services. Services or supplies of non-plan providers including self-referral to a specialist are not covered in a HMO except for Emergency Care, as defined in Part 1., Section I., of this Schedule of Benefits, and when coverage is authorized by Health Advantage and the Primary Care Physician.
 40. Not Medically Necessary. Services and supplies which are not Medically Necessary are not covered except for preventive health services for which coverage is otherwise specifically listed herein. Hospitalization that is extended for reasons other than medical necessity, e.g. lack

- of transportation, lack of caregiver at home, inclement weather, and other social reasons not justifying coverage for extended Hospital stay is not covered.
41. Nutritional counseling services. Dietary and Nutritional Counseling Services are not covered except in conjunction with Diabetic Self-Management Training, and for a nutritional assessment program provided in and by a Hospital and approved by Health Advantage .
 42. Nutritional supplements. Regular formulas, special formulas, and food additives are not covered except for formulas necessary for the treatment of phenylketonuria (an inherited condition that may cause severe mental retardation), and other heritable diseases.
 43. Obesity therapy or treatment. Regardless of medical diagnosis, services or procedures related to or complications resulting from the treatment of obesity, morbid obesity, including but not limited to weight loss programs, appetite suppressants, gastric stapling and/or gastric bypass are not covered.
 44. Orthognathic services. See exclusions for Dental Care and Reconstructive Surgery.
 45. Prescribed drugs and medications. Medications obtained by prescription through a managed pharmacy program including any outpatient medications, take-home medications, medications administered in conjunction with home health services, and medications prescribed after exceeding any maximum allowable benefits are not covered. Medications administered outside a Plan Physicians office except medications provided while confined as an inpatient are not covered. Medications provided for home infusion are covered under this HMO/POS plan.
 46. Private duty nursing. Private duty nursing, except for outpatient private duty nursing when determined to be Medically Necessary and ordered or authorized by the Primary Care Physician and approved by the Claims Administrators is not covered.
 47. Prosthetics and orthotic devices. General orthotic devices, dental appliances, splints or bandages provided by a physician in a non-hospital setting or purchased "over the counter" for the support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, elastic stockings except for surgical stockings (Jobst stockings), garter belts, specially ordered, custom made or built-up shoes, cast shoes, and shoe inserts designed to support the arch or effect changes in the foot alignment are not covered. Three (3) Bras per year will be covered following a mastectomy.
 48. Reconstructive Surgery. All services or procedures related to or complications resulting from Reconstructive Surgery are not covered except as specified in Part I, Section P. Reconstructive Surgery. Orthognathic procedures are not covered.
 49. Rehabilitative Treatment or Therapy. Any services, supplies, or therapy provided for developmental delay including, learning disabilities, communication delay, perceptual disorder, sensory deficit and motor dysfunctions is not covered except for services provided to prevent deterioration of function in children under the age of six (6).
 50. Relative giving services. Professional services performed by a person who ordinarily resides in the covered Member's home or is related to the covered Member as a Spouse, parent, Child, brother or sister, grandparent and grandchild, whether the relationship is by blood or exists in law are not covered.
 51. Services outside of Service Area. Services rendered outside of the Claims Administrator's Service Area, the need for which could reasonably have been foreseen by the Member prior to leaving the Service Area, except when such services have been prior approved by the Claims Administrator are not covered. Maternity care is not covered outside the service area if after the 36th week of pregnancy.
 52. Sex changes/sex therapy. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including sex therapy.
 53. Short stature syndrome. Any services related to the treatment of short stature syndrome except for growth hormone deficiency.
 54. Sleep study centers. Services provided by contracted sleep study centers are covered when

ordered by a Plan Provider. Services and supplies provided by or in connection with freestanding sleep study centers or sleep laboratories are not covered unless pre-approved by the Claims Administrator.

55. Smoking cessation/Caffeine addiction. Treatment of caffeine or nicotine addiction, smoking cessation prescriptions drug products, including, but not limited to, nicotine gum and nicotine patches are not covered.
56. Supplies. Medical Supplies regardless of where prescribed or purchased that are covered by the Prescription Medication Program are not covered. This includes supplies that are ordered by mail and ancillary diabetic supplies. Diabetic supplies are specifically covered by your Prescription Drug Benefit.
57. Telephone Consultation. Telephone calls by a Plan Provider to the Member for consultation or medical management, or for coordinating care with other health care professionals including reporting or obtaining tests and/or laboratory results except telephone calls made by a Plan Physician responsible for the direct care of a member in case management.
58. Temporomandibular Joint (TMJ) Dysfunction. Services or supplies for the treatment of TMJ are limited to and aggregate maximum of \$500 per Member per lifetime.
59. Transplant procedures. The following transplant procedures and services are not covered:
 - Animal to human transplants.
 - Artificial or mechanical devices designed to replace human organs.
 - Services provided beyond the benefit maximums.
 - Organ transplants that are not Medically Necessary.
 - Organ transplants considered experimental or investigational.
 - Small bowel transplantation.
 - Pancreas transplant not done simultaneously with kidney transplant with diabetic mellitus and End Stage Renal Disease.
 - Solid organ transplantation in patients for carcinoma except for liver transplants for patient with hepatoma confined to the liver.
60. Travel or accommodations. Travel or transportation as a treatment modality or to receive consultation treatment except emergency transportation and ambulance services covered under Part 1., Section G. and transportation in connection with organ transplant services Part 1, Section S. are not covered.
61. Vocational rehabilitation. Vocational rehabilitation services, vocational counseling, employment counseling or services to assist a Member in gaining employment are not covered.
62. War. Services or supplies provided for injuries sustained as a result of war, declared or undeclared, or any act of war; or while on active or reserve duty in the armed forces of any country or international authority are not covered.
63. Workers Compensation. Treatment of any compensable injury, as defined by the Workers' Compensation Law is not covered, regardless of whether or not the Member timely filed a claim for workers' compensation benefits. See Section 7.5, Workers Compensation.

B. Limitations as a Result of Major Disaster or Epidemic.

In the event that due to circumstances not within the commercially allowable control of the Claims Administrator, including, but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, computer failures or viruses, riot, civil insurrection, disability of a significant part of the Plan Providers' personnel or similar causes, the rendering of Professional or Hospital Services covered under this SPD is delayed or rendered impractical, Claims Administrators shall make a good faith effort to arrange for an alternative method of providing coverage. The Claims Administrator and Plan Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Attachment C

ARKANSAS PUBLIC SCHOOL EMPLOYEES PRESCRIPTION DRUG BENEFIT

A Prescription Drug Program is available to employees and dependents enrolled as plan participants in one of the Arkansas State and Public School Employee Benefits Division (EBD) sponsored medical plans. Prescription drug benefits are **not** available **without participation in one of the medical plans**. The Prescription Drug Program offers two convenient and cost effective ways to purchase prescription medications. The **retail prescription card** may be used to obtain prescription medications at a discounted cost from a participating pharmacy. **The Mail Order Prescription drug program** may offer additional cost savings on some specific medications that are required on a long term or maintenance basis.

Retail Prescription Drug Card Program

Drugs that are prescribed for short-term use should be filled using the retail prescription drug card. The Pharmacy Benefit Manager (NMHC Rx) administers the Retail Prescription Drug Card Program. This benefit is offered in conjunction with one of the Arkansas State and Public School Employee's Medical Plan options. Participants receive a prescription drug card, which may be used to purchase drugs from one of the NMHC Rx network pharmacies. The NMHC Rx network includes over 700 pharmacies in Arkansas and over 20,000 pharmacies nationwide. Most chain stores such as Wal-Mart, Walgreen's and Kroger participate in this network, as well as many independent pharmacies across the nation. Confirmation of participating Pharmacies may be obtained by calling NMHC Rx at 1-800-880-1188 or through its website at www.nmhcrx.com

The medications eligible for coverage will fall into one of three categories: generic, formulary brand, or non-formulary brand. The co-payment amount is dependent upon whether the prescription is for a generic, a formulary brand name (preferred) drug or a non-formulary brand name (non-preferred) drug.

A generic drug is identical in chemical composition to its brand name counterpart, has been approved by the Food and Drug Administration (FDA) to be therapeutically equivalent, and is as effective as the brand name product. The use of generics and formulary brand name drugs perform a vital role in controlling the cost of prescription drugs for both the participant and the plan. All non-formulary drugs have alternatives available preferred brand name drugs and possibly generics, both of which are more cost effective. Once a generic medication is released, the brand name counterpart becomes a non-formulary medication.

As new medications receive FDA approval and are released, they are reviewed by the NMHC Rx Pharmacy and Therapeutics committee (P&T). The P&T Committee makes a recommendation to the Arkansas State and Public School's Drug Utilization and Evaluation Clinical Committee (DUECC). The decision to add or not to add a medication to the formulary is first and foremost based upon efficacy. If there is not another alternative or the medication is superior to the current formulary alternative, then the medication is added. If it is found to be equivalent to current formulary alternatives, then a cost analysis is completed and determination is made. Medications may be deleted from the formulary on a quarterly basis (four times per year) with additions occurring throughout the year. Copies of the Arkansas State and Public School Employee's Formulary Preferred Drug List may be obtained by contacting NMHCRx at 800-880-1188 or at www.nmhcrx.com. This list is subject to change.

If your physician or pharmacist is unable to answer your drug information question, you can call the Arkansas Drug Information Center, a service provided by the UAMS College of Pharmacy at 1-888-228-1233.

In the traditional retail program co-payments for each type retail prescription are:

Generic*	\$10
Formulary Brand Name Drug (Preferred)	\$25
Non Formulary Brand Name Drug (Non-Preferred)**	\$50

*When a brand name drug becomes available in a generic alternative, the brand name drug immediately moves to the \$50 level and the generic becomes available for \$10.

**The minimum co-payment for any Non-Formulary Brand Name Drug is the lesser of \$50 or the cost of the prescription.

Traditionally, each retail prescription is limited to a 34-day supply. Prescriptions are dispensed according to the instructions of the prescribing physician. However, if the medical condition is such that the prescription drug is to be taken over a prolonged period of time (months or even years) it may be more beneficial to use the enhanced retail program or the mail order prescription program described below.

If a prescription is filled at an out-of-network pharmacy the participant will be responsible for paying 100% of the cost when the medication is dispensed plus \$1.25 fee for processing a paper claim.

The amount paid to purchase prescription drugs cannot be used to satisfy any annual deductible or out-of-pocket maximum under the medical plans.

Fourth Tier Benefit

This benefit is designed to cover medications, which were not previously covered by the plan such as medications for weight loss and smoking cessation. This benefit gives you access to the same discount the plan pays to network pharmacies. You will be responsible for the entire cost of the drug at the discounted rate.

Example:

Drug prescribed for weight loss	Retail Cost	\$150.00
	Average Wholesale Price	\$130.00
	Plan Discount 13%	\$113.10
	Dispensing Fee	<u>\$2.50</u>
	You Pay	\$115.60

This example shows a savings of \$34.40 from the retail cost you would have paid without this benefit. Simply give your pharmacist your prescription drug card as you always do and the amount you owe will be indicated to the pharmacist via electronic claims submission

Enhanced Retail Program

A 90 day supply of medications is available at retail pharmacies for three copayments. Prior to using this benefit, you must follow these guidelines:

1. You will need to obtain two 30 day supplies of medication or two fills at your participating pharmacy. This helps to ensure that prescriptions are appropriate for the duration of therapy. Please remember to keep your receipts or other proof of purchase.
2. If medication is still required after the two 30 day supplies or two fills, ask your doctor to write a prescription for up to a 90 day supply (if appropriate) with as many as three (3) refills.
3. The list of medications covered under this benefit is the same as the list of covered medications for the mail order benefit.

Please remember that some medications are excluded from this benefit. A complete list of excluded medications included in the mail order section below.

About the Enhanced Retail Program Pharmacy Copayments

Your copayment for a 90 day supply is equivalent to three (3) standard copayments based on the formulary status of the drug. Please refer to the following schedule:

Generic alternative	3X retail copayments of \$10 = \$30
Preferred drug	3X retail copayments of \$25 = \$75
Non-preferred drug	3X retail copayments of \$50 = \$150

Pharmacy Mail Order Program

The mail order prescription program is designed to assist individuals who take the same medication for a long period of time for conditions such as diabetes, high blood pressure, emphysema, arthritis, heart or thyroid conditions. You will need to obtain two (2) 30 day supplies of medication or two fills at a participating pharmacy. This helps to ensure that prescriptions are appropriate for the duration of therapy. Please remember to keep your receipts for proof of purchase. If medication is still required after the two (2) 30 days or two fills, you may ask The mail order program allows you to obtain a 90 day supply of certain medications at one time. You may use the mail order option at your retail pharmacy or by using NMHC Mail (mail order pharmacy). The mail order program allows a 90 day supply of medications for 3 months copayments. NMHC Mail can be reached at 800-881-1966 or www.nmhcmail.com.

The co-payments for the Mail Order Prescription drug program are as follows:

Generic	3X retail copayments of \$10 = \$30
Formulary Brand Name Drug	3X retail copayments of \$25 = \$75
Non Formulary Brand Name Drug	3X retail copayments of \$50 = \$150

Each mail order prescription is limited to a maximum quantity limit of a 90 day supply. The NMHC Rx mail order pharmacy is required by law to dispense the prescription in the exact quantity specified by the physician. Therefore, if the quantity prescribed is for less than 90 days per refill, NMHC Rx Mail will fill the exact quantity.

Arkansas State Employees and Public School Employees Mail-Order Exclusion List/Drug Class Description	Few examples of drugs in each class, but NOT limited to these drugs
Anti-Infective	All antibiotics, Lamisil, quinine, Urised
Anti-Viral	Famvir, Valtrex, Norvir, Ziagen
Blood Products	Neupogen, Epogen, Procrit
Anti-Anxiety	Diazepam, Lorazepam, Xanax
Anti-Depressants	Zoloft, Paxil, Amitriptyline
Psychiatric Agents	Methylphenidate, Adderall, Risperdal, Lithium, Lithobid
Sleeping Aids	Halcion, Sonata, Ambien
Muscle Relaxants	Cyclobenzaprine, Skelaxin
Pain Medications	Vioxx, Celebrex, Ibuprofen, OxyContin, Ms Contin, Hydrocodone, Lidoderm
Stomach Medications	Prilosec, Nexium, Protonix
Cough and Cold Products	Novahistine, Phenergan, Entex
Anti-Nausea Medications	Zofran, Kytril
Migraine Headache Products	Amerge, Imitrex, Zomig
Anti-Convulsants / Barbiturates	Phenobarbital, Pemoline
Central Nervous System Medications	Sinemet, Requip, Comtan
Specific Individual Drugs	Accutane, Arava, Lupron, Regitine, Retin A , Avita

Covered Prescription Drugs and Supplies:

- Drugs prescribed by a physician that require a prescription by federal law unless otherwise excluded.
- Insulin when prescribed by a physician, needles and syringes.
- Diabetic supplies (lancets, test strips)
- Ostomy supplies

Limits to Covered Prescription Drug Benefit:

The covered benefit for any one prescription will be limited to:

- The quantity limits established by the plan
- Refills only up to the time specified by a physician
- Refills up to one year from the date of order by a physician

Special Programs:

NMHC Rx, the Pharmacy Benefits Manager for the Arkansas State and Public School Employees, has several cost saving initiatives in place designed to assist our prescription drug program in delivering the best possible healthcare at the most reasonable cost. The programs described below are Prior Authorization, Quantity versus Time (QVT), Daily Dose Edits, Step Therapy and Special RX.

Prior Authorization (PA):

The Prior Authorization program helps to ensure the appropriate usage of certain medications by applying FDA approved indications and the manufacturer's guidelines to the utilization of certain medications. NMHC Rx has identified the medications that have a high potential for serious side effects, high costs, or high abuse potential.

The following steps should be taken in order to obtain a Prior Authorization:

- Your physician may call NMHC Rx at 1-888-880-1188 to obtain a prior authorization form. The form will be faxed to your physician's office.
- Once the physician completes the form, he should fax it back to NMHC Rx. A team of pharmacists and pharmacy technicians will evaluate the information provided by your physician.
- Once the prior authorization clinical guidelines are met, your prior authorization will be approved and entered into the system.
- If the clinical guidelines are **not** met, your physician will be sent a denial form.
- If the prior authorization is denied, you can still get your prescription but you will be financially responsible for the full charge of the prescription.
- Your physician may appeal the denial. The instructions to appeal the denied prior authorization request are included with the denial form.
(The appeal process is included at the end of this booklet.)

Drug Name	Usage (TX = Treatment)
Lamisil	TX of toe & fingernail fungus
Sporanox	TX of toe & fingernail fungus
Lidoderm patch	Tx of pain associated with post-herpetic neuralgia
Rebetron 1200	Tx of hepatitis
Rebetron 1000	Tx of hepatitis
Intron A	Tx of hepatitis
Wellbutrin SR	Tx of depression
Procrit	Stimulate production of red blood cells
Epogen	Stimulate production of red blood cells
Human Growth Hormone	Stimulated growth
Enbrel	Anti-inflammatory
Arava	Anti-inflammatory
Viagra, Muse, Caberject, Edex Papverine, Cialis, Levitra	Impotence
Retin-A & Accutane	Actinic keratoses
Lupron	Endometriosis
Synagis	RSV
Remicade	Anti-inflammatory

NMHC Rx Ascend Specialty Rx Services:

NMHC Rx Ascend Specialty Rx Services has agreed to provide selected specialty medications to our members. These specialty medications are high cost oral and self-administered injectable medications that are generally biotechnological in nature and usually require special handling and patient counseling. While this program is not mandatory at this time, participants may benefit from the services offered in this program. For your convenience, we have included a list of the medications provided by NMHC Rx Ascend. This list is current as of October 1, 2004. Please call NMHC Rx Ascend at 800-850-9122 with questions about this service. Normal business hours for Ascend are Monday through Friday, 8:00 am to 5:00 pm Central Standard Time.

Medications Available Through NMHC Rx Ascend

Actimmune	Cetrotide	Gonal-F	Leukine	Pergonal	Roferon-A
Alferon N	Copaxone	Helixate	Lovenox	Polygam S/D	Saizen
Alphanate	Cytogam	Hemofil-M	Lupron	Pregnyl	Sandostatin
AlphaNine SE	DDAVP	Humate-P	Lupron Depot	Procrit	Sandostatin Lar
Antagon	Enbrel	Humatrope	Monarc-M	Profasi	Serostim
Apligraf Disk	Epogen	Humegon	Monoclote-P	Profilnine SD	Synagis
<u>Aranesp</u>	Fertinex	Hylagan	Mononine	Proplex T	Temodar
<u>Arixtra</u>	Flolan	Hyate-C	Neupogen	Protropin	Thalomid
<u>Aurolatae</u>	Follistim	Infergen	Norditropin	Pumozyme	Thyrogen
Autoplex T	Fragmin	Immune Globulin	Novatrone	Rebetrol	TOBI
Avonex	Gamimune	Innohep	Novarel	Rebetron	Venoglobulin-I
Baygam	Gammar IV	Intron A	Novoseven	Rebif	Venoglobulin-S
Benefix	Gammar-P IV	Iveegam	Nutropin AQ	Recombinate	Visudyne
Betaseron	Gammagard S/D	Kineret	Ovidrel	Refacto	Vitravene
Bioclote	Genotropin	Kolate-DVI	Panglobulin	Remicade	Xeloda
Ceredase	Geref	Kogenate	Peg-Intron	Repronex	
Cerezyme	Gleevec	Konyne 80	Pegfrilgrastim	Respigam	

Quantity Vs Time Limits:

The QVT list is intended to clarify the usual quantity that constitutes a 34-day supply for these particular medications. The quantities allowed per each fill are based upon the dosing recommendations made by the manufacturer.

<u>Drug</u>	<u>Quantity limit per 34 days</u>
Impotency Medications (PA required)	
Caverject injection	6
Muse suppositories	6
Viagra tablets	6
Edex injection	6
Asthma Inhalers	
Albuterol,	4
Migraine Medications	
Migranal spray	1 box (4 vials)
Amerge, Imitrex tablets	9
Maxalt	6
Imitrex spray	1 box (6 vials)
Imitrex injection	4
Imitrex kit	2
Frova	9
Axert	6
Zomig 5mg	3
Zomig 2.5 mg	6
Relpax	6
Multiple Sclerosis	
Betaseron	15 vials
Avonex	4 vials
Copaxone	32 vials
Miscellaneous	
Zithromax	6
Lamisil	30 per fill, 84 per year
Diflucan 150 mg	1 per fill
Zelnorm	12 wks annually (female only)
Ambien	15
Sonata	15

Daily Dosing Edits

On April 15, 2001 Arkansas State and Public School Employees implemented Daily Dose Edits. Daily Dose Edits are designed to notify members when they are taking lower strength medications multiple times a day when higher strengths are available.

Brand Name	Strength Description	Recommended Strength	Secondary Message
Actos	15Mg	30Mg	Use one 30mg
Celexa	20Mg	40Mg	Use one 40mg
Effexor	37.5Mg	75Mg xr	Use one 75mg xr
Effexor xr	75Mg	150Mgxr	Use one 150mg xr
Lescol	20Mg	40Mg	Use one 40mg
Lescol	40Mg	80Mg xl	Use one 80mg xl
Lipitor	10Mg	20Mg	Use one 20mg
Lipitor	20Mg	40Mg	Use one 40mg
Lipitor	40Mg	80Mg	Use one 80mg
Paxil	10Mg	20Mg	Use one 20mg
Paxil	20Mg	40Mg	Use one 40mg
Pravachol	10Mg	20Mg	Use one 20mg
Pravachol	20Mg	40Mg	Use one 40mg
Prozac	10Mg	20Mg	Use one 20mg
Zocor	10Mg	20Mg	Use one 20mg
Zocor	20Mg	40Mg	Use one 40mg
Zocor	40Mg	80Mg	Use one 80mg
Zoloft	50Mg	100Mg	Use one 100mg

Step Therapy:

“Step-therapy” is a treatment approach in which more traditional medications are encouraged before graduation to newer, more expensive, and more sophisticated medicines. For example, under step-therapy, a person with a new prescription for a Cox 2 Inhibitor would—if deemed an inappropriate candidate for this form of treatment—be denied the prescription and encouraged to try a generic substitute (such as prescription strength Motrin or Naprosyn). That person would then have the option of having his or her doctor call for a prior authorization, or purchasing the Cox 2 Inhibitor at the full price without the pharmacy benefit

<u>Drug Name</u>	<u>Drug Class</u>
Celebrex, Bextra	Cox 2 Inhibitors

Specific Covered Medications:

Legend Vitamins

Prenatal Vitamins in solution - limited to 50cc per fill

Insulin - standard days limit, no units limits

All syringes - no days limits, units limits 100

Blood Glucose and Urine Strips - no units limit as of 3/6/00

Blood testing tapes

Blood testing tablets

Lancets - no units limit

OTC Prilosec is covered with \$5 copay for box of 42 at pharmacy.

*If insulin or an oral diabetic is in member's history within the last 2 days from the submit date, then all diabetic supplies will pay with a zero co-pay. The pharmacy must submit the insulin or oral diabetic before submitting the supplies or the system will not be able to verify that they are using those medications and it will assess a co-pay.

*Mail Service will provide coverage for ostomy supplies. There will be two copays applied for a 3-month supply.

Other program restrictions:

- Gabapentin: (generic Neurontin) is only covered at the \$10 copayment if being used for seizure disorder or postherpetic neuralgia. Otherwise it will cost \$50.
- Singulair is covered only for the treatment of asthma in conjunction with a short acting beta agonist (rescue inhaler) long acting corticosteroid in patients 18 and older.
Exception: member has a condition in which the use of one or both inhalers is medically contraindicated.

Excluded Prescription Drugs:

If a drug is not covered by the plan, you will be responsible for the entire cost.

- Over the Counter products that may be bought without a written prescription or their equivalents. This does not apply to injectable insulin, insulin syringes and needles and diabetic supplies or OTC Prilosec, which are specifically included.
- Devices of any type even though such devices may require a prescription. This includes (but not limited to) therapeutic devices or appliances such as implantable insulin pumps and ancillary pump products.
- Immunization agents, biological serum, vaccines.
- Implantable time-released medications.
- Experimental or investigational drugs or drugs prescribed for experimental, Non-FDA approved, indications.
- Drugs approved by the FDA for cosmetic use only.
- Compound chemical ingredients or combination of federal legend drugs in a Non FDA approved dosage form.
- Fertility medications
- Nutritional supplements except for metabolic conditions only.
- Smoking cessation medications
- Weight loss medications

Confidentiality and Personal Health Information

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice, which is attached to this document.

This plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health care operations and plan administration, or as permitted, or required by law. By law, the Plan has required all of its business associates to observe HIPAA's privacy rules. In particular, the plan will not without authorization disclose protected health information for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of **certain** disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. If you have questions about the confidentiality of your health information or wish to file a complaint under HIPAA, please contact the Employee Benefits Division's Privacy Officer, at 1-501-682-5499 or 1-877-815-1017.

Member Appeals Process:

Level 1

Member may appeal any claim denial to NMHC Rx within 180 days of denial. NMHC Rx will review appeal request and provide a written response to the member within 30 days of written request.

Level 2

Member may appeal this decision to the office of Employee Benefits Division within 180 days of initial response. EBD in concurrence with the EBD Physician Advisor will meet to discuss and provide a written response to the member within 30 days of receipt of the Level 2 appeal.

If you have questions about the retail drug program, the mail order program or your prescription order, please call NMHC Rx toll free at 1-800-880-1188. The NMHC Rx customer service hours are:

Monday through Friday:	7:00 AM to 10:00 PM Central Standard Time
Weekends and all holidays:	8:00 AM to 6:00 PM Central Standard Time

Coverage under this plan will terminate on the date a participant is no longer enrolled in a covered Arkansas State and Public School medical plan.

The Arkansas State and Public School Health and Life Insurance Board reserves the right to amend or modify the plan at any time by actions of its officers. Questions regarding the Arkansas State Prescription Program may be directed to NMHC Rx at 1-800-880-1188.

Attachment D

Mental Health, Behavioral Health, and Substance Abuse Treatment Coverage

Corphealth, Inc., in cooperation with the policy issued by Employers Health Insurance Company, combines the cost savings incentives with freedom of choice. When you see participating providers, you receive services at a discounted level. At the same time, you retain the flexibility to see any qualified, licensed mental health practitioner statewide.

In addition, the Employee Assistance Program (EAP) is a benefit provided to enrollees of this plan.

Arkansas Public School Employees

www.corphealth.com

Arkansas Helpline 1-866-378-1645 (toll free)

Arkansas Public School Employees Mental and Behavioral Health Benefits

If you chose to participate in any of the medical health plans, you automatically receive the Corphealth Employee Assistance Program (EAP) as well as the Mental Health and Substance Abuse (MHSA) Benefit Program. Corphealth coordinates all behavioral health care for Arkansas Public School Health Care enrollees. This benefit program and network of mental healthcare providers is completely separate from your medical plan, regardless of the medical plan you select.

Accessing your Mental Health, Substance Abuse and Employee Assistance Benefits is easy.

***You MUST access your behavioral health care benefit by
calling the Arkansas Helpline at 1-866-378-1645.***

The Helpline is available 24 hours a day, 365 days a year. When you call the Helpline you will:

- Have immediate access to a professional to help you assess your needs, sort through your options, and find effective resources.
- Obtain pre-certification for mental health, substance abuse treatment, or EAP services
- Receive individualized referrals to behavioral health resources in your community
- Receive telephonic and/or face-to-face EAP sessions with one of the EAP affiliate counselors

You can maximize your behavioral health benefit by:

Using a Corphealth network provider for Managed Care Services

Using a Corphealth EAP affiliate for EAP services

Pre-certifying all services through the Arkansas Helpline at 1-866-378-1645

The mental health and substance abuse benefits available under this Policy are distinct from the Major Medical Plans. This document is an outline of the insurance provided by the group Policy and it does not extend or change the coverage afforded by such group Policy. The coverage describe here is subject to all the provisions, terms, exclusions and conditions of the Employers Health Insurance Company group Policy. The provisions of this Policy are administered by Corphealth, Inc., and use the Corphealth Provider Network. Corphealth is the designated agent and administrator for this plan. Questions regarding your Mental Health, Substance Abuse and Employee Assistance Program Benefits should be directed to Corphealth at 1-866-378-1645.

Schedule of Benefits

<u>Benefit Description</u>	<u>PPO Network Provider</u>	<u>Out-of-Network Provider</u>
Employee Assistance Program (EAP) Telephonic consultation and face-to-face short term/brief issue resolution counseling	Up to eight (8) EAP sessions per episode with no Co-Payment.	Not Covered
Smoking and Tobacco Use Cessation Program, "AR Quit Now" 4 terms per life time, only covered employee and covered spouse eligible	Mandatory 3 individual, telephonic or web-based educational sessions, or unlimited group educational sessions. Also option of either 8 weeks of bupropion at 50% cost sharing or 12 weeks nicotine patch at 100% coverage	Not Covered
Behavioral Health Annual Maximum Out-of-Pocket - Individual - Family	 \$1,500 \$3,000	 \$1,850 \$3,750
Maximum Lifetime Benefit	\$1,000,000	\$25,000
Inpatient Services	\$500 copay + 20% coinsurance/ admit	\$625 copay + 45% coinsurance
Outpatient Services – Traditional	\$35 copay/visit	\$35 copay + 25% coinsurance
Partial Hospital/Day Treatment	\$100 copay first visit +20% coinsurance	\$125 copay first visit +45% coinsurance
Outpatient Services – Intensive	\$100 copay first visit +20% coinsurance	\$125 copay first visit +45% coinsurance
Residential Treatment	20% coinsurance	45% coinsurance

Preferred Provider Network

The Preferred Provider Network consists of mental health and substance abuse providers designated by Corphealth including Hospitals, Qualified Treatment Facilities, Qualified Practitioners, and other providers, which have entered into agreements. Benefits are typically paid at the higher benefit levels (coinsurance, maximum lifetime benefit, co-pay) if Services are provided by a Preferred Network Provider. Preferred Providers are paid directly by Corphealth, except for your copay and coinsurance. You may get help finding an appropriate Preferred Network Provider by calling the Arkansas State Employee Helpline, 1-866-378-1645, or visiting the Corphealth website (www.corphealth.com).

Preauthorization/Precertification Requirement

If Preauthorization is not obtained, benefits under this Policy will be denied and you will be responsible for payment. When you or your designee calls for preauthorization, Corphealth will:

- Advise you if the proposed treatment plan is a covered expense;
- Provide you with a certification number; and
- Continue to review services throughout the course of your covered service.

Pre-certification is not a guarantee of payment. Payment determinations are made at the time claims are submitted. All payments are subject to policy guidelines, medical necessity, and member eligibility at the time services are performed.

- Anesthesia services for Electro Convulsant Therapy is only covered when provided at a Bridgeway facility and requires pre-authorization.

We must be notified within twenty-four (24) hours after your confinement or Emergency Care.

Maximum Allowable Fees for Non-Network Providers

The Maximum Allowable Fee for services provided by Non-Network Providers is based on the fee negotiated with Network Providers within the Service Area. You are responsible for 100% of charges in excess of such maximum allowable fee. Such excess amounts are not considered Covered Expenses and will not apply to the Deductible or the Out-of-Pocket Limits.

Covered Expenses

Covered Expense means an expense for a Medically or Psychologically Necessary Service as described in the Policy and Certificate of Insurance. Covered Services include Covered Expenses for Mental Disorders and incidents of Substance Abuse furnished as Outpatient Services, Intensive Outpatient, Partial Hospitalization, Residential Treatment, and Inpatient Services. Covered Services must be performed by Qualified Practitioners and Qualified Treatment Facilities.

Emergency care

Emergency care means services provided for a Mental Disorder or an incident of Substance Abuse manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to:

- result in placing the health of that individual in serious jeopardy;
- serious impairment of bodily functions;
- or serious dysfunction of any bodily organ or part.

Corphealth must be notified within twenty-four (24) hours after your confinement for Emergency Care.

Medically Necessary

Medically Necessary means appropriate and essential for the purpose of diagnosing, palliating or treating a Mental Disorder or Substance Abuse condition, or its symptoms. Such Services and associated treatments or products must be:

- In accordance with nationally recognized standards of medical practice and generally accepted as safe, widely used and effective for the proposed use;
- Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
- Not primarily for the convenience of the patient, physician, or other health care provider,
- Clearly substantiated by the medical records and documentation concerning the patient's condition;
- Performed in the least restrictive setting required by the patient's condition
- Supported by the preponderance of nationally recognized peer review medical literature, if any, published in peer reviewed literature in English as of the date of Service; and
- Not expressly excluded under this Policy.

Psychologically Necessary

Psychologically Necessary means appropriate and essential for the diagnosis, evaluation and/or treatment of a Mental Disorder or Substance Abuse condition. Such Services and associated treatments or products must be:

- In accordance with nationally recognized standards of mental health professional practice and generally accepted as safe, widely used and effective for the proposed use;
- Supported by the preponderance of nationally recognized peer review medical and mental health professional literature, if any, published in peer reviewed literature in English as of the date of Service;
- Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
- Not primarily for the convenience of the patient, physician, or other health care provider;
- Clearly substantiated by the medical records and documentation concerning the patient's condition;
- Performed in the least restrictive setting required by the patient's condition; and
- Not expressly excluded under the Policy.

Limitations and Exclusions

Your group may have specific limitations and exclusions not included in this list. Please check your Group Policy/Certificate of Insurance for the complete listing. The Group Policy/Certificate of Insurance is the document upon which benefit payment will be determined.

1. Any non-Emergency Care received without Preauthorization;
2. Services not Medically Necessary or Psychologically Necessary for diagnosis or treatment of a Mental Disorder or Substance Abuse condition;
3. Inpatient Services when You are in Observation Status;
4. Any Service which is Experimental, or for Research Purposes;
5. Services:
 - (a) Not furnished by a Qualified Practitioner or Qualified Treatment Facility;
 - (b) Not authorized or prescribed by a Qualified Practitioner;
 - (c) For sexual or gender identity disorders;
 - (d) Beyond those necessary for the diagnosis of mental retardation, pervasive development disorders (including autism) disruptive behavior disorders (including conduct disorder and oppositional defiant disorder).

- (e) For pain with physiological origins unless We determine such pain has psychological or psychosomatic components;
 - (f) Provided in connection with, or to comply with, involuntary commitments, police detentions and other similar arrangements, unless authorized by Us as Medically Necessary or Psychologically Necessary;
 - (g) For Methadone treatment, LAAM, Cyclazine or equivalents;
 - (h) For sexual dysfunction including sex therapy;
 - (i) For any Mental Disorder or Substance Abuse condition related to disorders, disabilities or addictions designated in diagnostic categories of the Diagnostic and Statistical Manual IV of the American Psychiatric Association defined by EDP;
 - (j) For which no charge is made, or for which You would not be required to pay if You did not have this insurance, unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law Furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law;
 - (k) Furnished while You are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies for any service-connected condition;
 - (l) Which are not rendered or not substantiated in the medical records;
 - (m) That are not listed as a Covered Expense;
 - (n) Provided by a person who ordinarily resides in your home or who is a Dependent;
 - (o) That are performed in association with a Service that is not covered under the Policy;
 - (p) That are billed incorrectly or billed separately, but are an integral part of another billed Service, as determined by Corphealth.
6. Charges in excess of the Maximum Allowable Fee for the Service;
 7. Pre-Existing Conditions to the extent specified in the Certificate and on the Schedule of Benefits;
 8. Any Expense Incurred before the Effective Date under the Policy;
 9. Any Expense Incurred after the date Your coverage under the Policy terminates;
 10. Any Expense Incurred exceeding the Lifetime Maximum Benefit under the Policy;
 11. Custodial Care and Maintenance Care;
 12. Any prescription or over-the-counter drug, medication or biological;
 13. Vitamins, dietaries, and any other non-prescription supplements;
 14. Services for which there is payment or expense coverage provided or payable under any Major Medical Plan, other health insurance coverage, self insurance coverage, automobile, homeowners, premises, or any other similar coverage;
 15. Any loss contributed to, or caused, by (a) War or any act of war, whether declared or not; or (b) Any act of armed conflict, or any conflict involving armed forces of any authority;
 16. The treatment of Mental Disorder or Substance Abuse condition unless specifically provided in the Mental Health Covered Services provision of the Certificate and shown on the Schedule of Benefits - Mental Health;
 17. Private duty nursing;
 18. Loss due to commission or attempt to commit a civil or criminal battery or felony;
 19. Services rendered by a standby physician or assistant surgeon, unless Medically Necessary;
 20. Treatment of obesity;
 21. Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes;
 22. Educational or vocational therapy, services and schools, including, but not limited to, videos and books;
 23. Communications or travel time;
 24. Lodging accommodations or transportation, except as specified in the Certificate;
 25. Charges for services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician);

26. Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
27. Any charges, including Qualified Practitioner charges, which are incurred if You are admitted to a Hospital or Qualified Treatment Facility on a Friday or Saturday unless (a) Your Confinement is due to Emergency Care; or (b) Treatment or therapy is performed on that same day;
28. Alternative Medicine;
29. Marital counseling;
30. Treatment of any Mental Disorder, incident of Substance Abuse or other conditions that arises from, or is sustained in the course of, any occupation or employment for compensation, profit or gain; or
31. Any Service ordered by a court or government agency, which is not determined by Corphealth to be Medically Necessary or Psychologically Necessary.

Summary: All services require precertification for all levels of care (including EAP).

EAP Distinction:

The Arkansas STAR Employee Assistance Program (EAP) is a program of mental health and substance services offered to Employees and Dependents at no charge. All services are rendered by EAP counselors and include assessment, counseling, and issue resolution. The Arkansas STAR EAP is designed to help you resolve short-term problems related to family marital and peer relationships, parenting, finances, school, elder care, etc. The following conditions apply to the EAP:

- Medical necessity is not required, however, pre-authorization must be obtained
- All EAP services must be provided by a Corphealth approved EAP affiliate
- Sessions are limited to eight per episode
- Psychological Testing, any facility based care, or services rendered by a psychiatrist are not covered under the EAP

Attachment E

Life Insurance Options for Arkansas Public School Group Employees

Basic Life and AD&D:

\$5,000.

All new employees who participate in the school health insurance plan automatically receive \$5,000 in basic life and AD&D insurance benefits. Monthly Premium: \$0.65.

Supplemental Life and AD&D:

<u>Classification By Basic Annual Earnings</u>	<u>Insurance Amount</u>	<u>Monthly Premium</u>
\$10,000 or less	\$20,000	\$ 5.00
\$10,001 - \$15,000	\$30,000	\$ 7.50
\$15,001 - \$20,000	\$40,000	\$10.00
\$20,001 - \$25,000	\$50,000	\$12.50
\$25,001 - \$30,000	\$60,000	\$15.00
\$30,001 and above	\$70,000	\$17.50

Dependent Life:

<u>Coverage Amount</u>	<u>Monthly Premium</u>
\$2,500	\$1.20

Basic Life/AD&D

- 1) All new employees who participate in the school health insurance plan automatically receive \$5,000 in basic life insurance benefits. These new employees are enrolled in the life when the health application is completed.
- 2) The basic \$5,000 life insurance is packaged with the health premium and is billed on the health insurance bill provided by EBD, regardless of which school health plan is chosen. Premiums for this coverage are payroll deducted from the employee's paycheck.
- 3) Beneficiary designations for the \$5,000 Basic Life/AD&D need to be made using USABLE Life form APSGAPP 7-02 and completing the orange areas. This is the same form that is used to apply for Supplemental Life. It is very important that employees complete this form to ensure insurance proceeds are paid appropriately should a claim occur.
- 4) Please keep a copy of this form for your records and provide a copy and the original to the School Business Official. The original will be submitted to USABLE Life.
- 5) Please request from your School Business Official a new Basic and/or Supplemental Life insurance booklet.

Supplemental Life/AD&D and Dependent Life

- 1) Employees should use USABLE Life form APSGAPP 7-02 to apply for Supplemental Life/Dependent Life and designate their beneficiary.
- 2) All full-time employees, regardless if they participate in the school health insurance plans or not, are eligible to participate in the USABLE Life Supplemental Life/AD&D and Dependent Life insurance program.
- 3) New hires after October 1 each year are eligible for Supplemental Life/AD&D and Dependent Life insurance guaranteed issue as long as they apply within 31 days of their hire date. All areas of the application should be completed, with the exception of medical questions.
- 4) Employees who are not new hires and would now like to apply for the Supplemental Life/AD&D and/or Dependent Life program may do so. They must complete all areas of the application, including medical questions, as they will be medically underwritten for the Supplemental Life/AD&D and/or Dependent Life. Premiums for this coverage are payroll deducted from the employee's paycheck.
- 5) Please keep a copy of this form for your records and provide a copy and the original to the School Business Official. The original will be submitted to USABLE Life.
- 6) Your School Business Official will be notified if your application is declined.
- 7) Please request from your School Business Official a new Basic and/or Supplemental Life insurance booklet.

Benefits for Retirees

Basic and Supplemental Life Insurance: The amount of Basic and Supplemental Life Insurance will be reduced by fifty percent (50%) on the date of an employee's retirement provided they become an annuitant under the Teachers' Retirement System, and they participate in the health benefit plan for retirees. If they do not meet both of these requirements, their Basic and Supplemental Life insurance will terminate on the date of their retirement. In order to retain life insurance coverage at retirement, the employee must complete form #APSG-RET (7-01), and remit it to USABLE Life. Premiums for this coverage are deducted from the employee's annuity check. In the event the annuity check is not sufficient to deduct the premiums, USABLE Life will bill for the premiums directly to the retired employee's home address.

Accidental Death and Dismemberment Insurance - Basic and Supplemental AD&D coverage will terminate on the date of retirement.

Dependent Life Insurance: Dependent Life coverage will terminate on the date of retirement.

The USABLE Life Customer Service department is available to answer questions regarding the Basic Life/AD&D; Supplemental Life/AD&D and Dependent Life for school employees. Our dedicated toll-free number for school districts is:

1-800-370-5854

Email: custserv@usablelife.com

Attachment F

CONTACT INFORMATION

HEALTH INSURANCE CARRIERS

Arkansas Blue Cross & Blue Shield (offers PPO Plan)

P. O. Box 2181

Little Rock, AR 72203

Toll Free☐

(800) 482-8416

E-mail.....publicschoolemployees@arkbluecross.com

Website address:.....www.arkbluecross.com

Health Advantage (offers HMO and POS plans)

P. O. Box 8069

Little Rock, AR 72203

Toll Free☐

(800) 482-8416

E-mail.....publicschoolemployees@arkbluecross.com

Web site address www.healthadvantage-hmo.com

NovaSys Health (offers HMO, POS, PPO and HSA PPO plans)

P. O. Box 25230

Little Rock, Arkansas 72221

Local Office☐

(501) 975-4853

Toll Free☐

(800) 294-3557

Web site address www.novasyshealth.com

QualChoice/QCA (offers HMO and POS plans)

10825 Financial Centre Parkway, Suite 400

Little Rock, AR 72211

Toll Free☐

(800) 782-5246

Local Office (501) 228-7111

E-mail Select "Contact Us" button on website

Web site address www.qcark.com

HEALTH SAVINGS ACCOUNT

DataPath (DPAS - Data Path Administration Services)

1601 West Park Drive, Suite 9

Little Rock, AR 72204

Local Office ☐

(501) 687-6954

Toll Free☐

(877) 685-0655

E-mail.....PSE@idpas.com

Web site address www.idpas.com

PRESCRIPTION COVERAGE

NMHC Rx (National Medical Health Card Rx) replacing AdvancePCS, Eff. 10-1-04

320 Executive Court, Suite 201

Little Rock, AR 72205

Toll Free (800) 880-1188

Web site address www.nmhcrx.com

Click on "contact us" and then go to "Member Services" to send an email message.

NMHC Mail (Mail Order Pharmacy)

PO Box 407096

Ft Lauderdale, FL 33340-7096

Toll Free (800) 881-1966

Web site address www.nmhcmail.com**LIFE INSURANCE****USAbLe Life**

320 West Capitol, Suite 700

P.O. Box 1650

Little Rock, AR 72203

Toll Free Customer Service (800) 370-5856

Toll Free Life Claims (800) 648-0271

Local Office (501) 375-7200

Web site address www.usablelife.com**BEHAVIORAL HEALTH, MENTAL HEALTH, SUBSTANCE ABUSE & StarEAP****Corphealth / STAR EAP**

1701 Centerview Dr., Suite 101

Little Rock, AR 72211

Toll Free 1-866-378-1645

E-mail customerservice@corphealth.comWebsite site address www.corphealth.com

On website, click "Members" and go to Member's Login.

Use Username: STAREAP and Password: STAREAP

GENERAL BENEFIT INFORMATION AND ASSISTANCE**Employee Benefits Division (EBD)**

(Mailing address)

P.O. Box 15610

Little Rock, AR 72201

(Physical address)

1515 West 7th, Suite 300

Little Rock, AR 72231-5610

Phone Numbers

Toll Free (877) 815-1017

Local Office (501) 682-9656

OnlinePublic site address www.arkansas.gov/dfa/ebdARBenefits system www.ARBenefits.orgGeneral E-mail Address AskEBD@dfa.state.ar.us

Community Resources

Easter Seals Arkansas

3920 Woodland Heights Road
Little Rock, AR 72212-2495
Phone: (501) 227-3600

Arkansas Spinal Cord Commission

1501 North University, Suite 400
Little Rock, AR 72207
(501) 296-1792

American Red Cross

401 S. Monroe
Little Rock, AR 72205
(501) 614-4410

Arkansas School for the Blind

2600 W. Markham
Little Rock, AR
(501) 296-1810

Arkansas School for the Deaf

2400 W. Markham
Little Rock, AR 72205
(501) 324-9506

American Heart Association

909 W 2nd Street
Little Rock, AR 72201
(501) 375-9148

American Cancer Society

901 N University Ave
Little Rock, AR
1-800-227-2345

American Lung Association

211 Natural Resources Drive
Little Rock, AR 72205
(501) 224-5864

American Diabetes Association

212 Natural Resources Drive
Little Rock, AR 72205
(501) 221-7444

NOTES:

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